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.	
Service	Integrated Community Services
Commissioner Lead	
Provider Lead	
Period	2017/18
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

15.4 million adults in England have a long term condition, almost 1 in 3 people. "The ambition to move care closer to home has resulted in some reduction in lengths of stay in hospital, but further significant changes are needed in the way care is delivered"1 The aim of integrated multi-disciplined teams is to:

- Reduce complexity of services– the reduction of fragmented services and tasks will improve consistency and quality of community care. This is achieved through creating larger integrated locality facing teams with a shared set of skills and assessment processes which includes staff with specialist knowledge.
- "Wrap" multi-professional services around the patient who are part of a larger primary care team – both generic and specialist staff with defined goals.
- Multidisciplinary teams providing care for people with complex needs, including social care, mental health and other services. This should also include close involvement of patients and their carers in setting goals and planning care.
- Support teams with specialist medical input, with consultant services particularly for older people and those with chronic conditions.
- Create services that offer an alternative to hospital stay. Two components to this are proactive services which prevent admission and reduce length of stay. Preventing admission requires accurate assessment rapidly and responsive alternative service provision.
- Have an infrastructure to support the model based on these components including better ways to measure outcomes.
- Develop capabilities to harness the power of the wider community.

"Achieving integrated care would be the biggest contribution that health and social care services could make to improve the quality and safety"2. The aim of the integrated community service model is to provide a seamless, holistic health care service within a person's own home, including long term residential care and/or clinic settings, and education settings. This is achieved through delivering care that is based on a person's needs, wrapping the service around the patient to make it meaningful.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**Y**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Y**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**Y**
Domain 4	**Ensuring people have a positive experience of care**	**Y**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Y**

2.2 Local defined outcomes

NHS Midlands and East [(2)] has agreed 5 key ambitions regarding service improvement which includes:

1. The elimination of stage 2,3 and 4 pressure ulcers
2. Making every contact count.
3. To improve quality and safety in Primary Care
4. Strengthen partnerships between the NHS and local government.
5. Create a revolution in patient and customer experience.

CCG specific outcomes

6. Patient centred and high quality co-ordinated health and social care services
7. Care which is closer to home and community based leading to a reduction in emergency admissions and length of stay in the over 65s and those with long term conditions
8. The prevention of unnecessary admission, or readmission, to hospital or long term care
9. The maximisation of independent living and residual skills
10. The prevention of avoidable deterioration and promotion of optimum levels of independence and self-care appropriate to individual need and ability
11. EOL patients die in their preferred place of death
12. Provide a high quality pulmonary rehabilitation based on NICE Guidelines which improves respiratory function, symptoms, quality of life and independence
13. A case management and care planning approach is used to maximise patient care
14. Patients and carers report a high level of satisfaction and experience of services
15. Staff have the skills, capacity, and capability to deliver excellent patient care

3. Scope

3.1 Aims and objectives of service

Aim

The aim of the integrated community service model is to provide a seamless, holistic health care service within a person's own home (including residential care, and in the case of enhanced services to nursing homes). This will be achieved through delivering care which is patient centred, wrapping around service provision to make it meaningful to the patient.

The integrated teams will case find frail older people, by utilising predictive and risk stratification tools to actively case find and identify patients who are most vulnerable from admission and/or health deterioration. The teams will support patients manage their health conditions and to achieve the best quality of life and independence possible through robust health assessments and care planning.

The aims and objectives of the integrated service will fit within the three core QIPP domains of efficiency, effectiveness and patient experience.

Objectives

- To create access to better, more integrated care outside hospital through the delivery of an integrated community health service which works in partnership with health and social care teams including mental health services, social care, secondary care and the voluntary sector to ensure person centred care is provided.
- To provide a rapid response and crisis intervention 7 days per week
- To simplify and streamline access to adult community services through the provision of a Single Point of Access/Community Hub for all enquiries and referrals for adult community services from GP Practices, social care, secondary care and patients and any other agencies such as police, which operates 8am to 8pm 7 days a week.
- To work closely with General practice, attending MDTs to identify those with deteriorating health, increasing health and social care needs to proactively manage and provide wrap around care promoting independence and self-care.
- To reduce duplication and gaps through the effective management of integrated teams
- To reduce unnecessary admissions and readmission through proactive case management, liaising with secondary care to actively facilitate safe effective transfers both in and out of acute sector care in a timely manner and reduce overall length of stay/avoid inappropriate admission where appropriate.
- To ensure that integrated health services are patient centred and equitable
- To utilise predictive and risk stratification tools to actively case find and identify patients who are most vulnerable from admission and/or health deterioration.
- Work in partnership with Adult Social Care and care agencies to provide a holistic health and social care package to support independence.
- To contribute to the reduction of unplanned care needs, reduction of hospital admissions and readmissions, reduced length of stay, and the reduction in the number of people requiring long term residential care.
- To support patients receiving end of life care to die with dignity, supported in their preferred place of death
- To scope, plan and develop planned care services as appropriate.

3.2 Service description/care pathway

Referrals into Integrated Care Teams:
All referrals to be actively triaged by therapy and nursing staff to ensure appropriate, efficient utilisation of services and ensure services are ‘wrapped around’ the patient according to patient needs. This will be achieved through a single point of access through a single approach. Triage from therapy and nursing staff to streamline the patient journey, reduce duplications and improve consistency of service delivery. Actively engage and promote horizontal and vertical integration with mental health services for older people.

Avoided Admission:
To provide a rapid response service to patients needs in order to prevent an admission into hospital.

Care Co-ordination:
The service will support the Care Coordination Team at admission/discharge from NUH through in reach and the proactive pull patients into community services. This will be based on the following principles:

- Care coordination will be collaborative across health and social care colleagues, community and NUH nursing and therapy and social care staff
- Care coordination will support the identification and tracking those patients with an anticipated complex discharge from the point of admission (choose to admit)
- A pro-active "pull" of the patient through the system from acute to community / primary care
- Care coordination will support a programme of care that is established and maintained throughout the hospital stay
- Care coordination will aspire to one assessment carried out to meet the needs of transfer to assess
- Care coordination will support patients to be transferred to on-going care within 24 hours of being flagged as medically stable
- There will be a shared understanding across the hospital / community interface to ensure risk is managed
- There will be consistent communication / use of language with the patient and carer regarding the transfer of care and how their on-going care needs will be met

Transfer to assess
To facilitate a reduced length of stay with swift, timely, safe discharges into the community with community follow up to reduce readmissions and support further self-care management and to assess on-going health needs.

Support Monthly Multi-Disciplined Team Meetings (MDT) – to be held within the GP practice. Appropriate members of the integrated team to be the patient advocate as well as clinically discuss on-going care management across the wider integrated team. There will be a clear identification of a case manager and service lead for the care pathway of individual patient, based on the needs assessment.

Implement Advance Care Planning – The integrated team will work closely with established lead, patients, relatives and primary care, secondary care/specialist palliative care to ensure that advanced care plans are discussed with the patient, family and where appropriate care staff. Preferred place of death wishes are to be clearly documented and the wishes of the patients supported as much as possible with multidisciplinary advance care planning arrangements as well as assessing/ confirming/ documenting the mental capacity of the patient. 'Special Patient Notes' and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms are to be accurately completed and registered with out of hour's providers and community teams and are available to East Midlands Ambulance Service (EMAS) on arrival to the home and through the EMAS electronic systems. The identified lead will also be responsible for ensuring that end of life care plans are discussed with patients and their relatives as appropriate. Advance care plans, patient wishes and DNACPRs will be held both in the patient's notes and (for patients in long term residential care) by the care home staff. The GP lead is responsible for updating the GP records, and 'THE PROVIDER' are responsible for documenting on the community module of the patient records. Anticipatory medications will be discussed with the GP to ensure proactively

anticipatory prescribing to avoid crisis when the patient deteriorates, this will particularly support the out of hours, or if applicable by the non-medical prescriber in discussion with the GP. These plans will be clearly available for secondary care providers and transport providers.

Personalised Care Plans – Personalised care plans are required for all patients who have a long term condition to assist them to achieve a self-care management plan, to include escalation advice should their health deteriorate. There is to be an emphasis on self-care, management of exacerbations and rescue and anticipatory medications management.

Utilisation of Digital Technologies – to support patients with self-care management and promote ownership of patients own health and health management. Utilisation to be promoted particularly for residents in residential care homes to support care home staff in early identification to changes in the patients' condition and increase the care assistant's knowledge of normal and abnormal parameters, implications and management.

Self-Care
To support Self-Care is a key principle promoting 'support to thrive'. Patients to have a proactive, patient centred care plan, which is communicated between teams and organisations as appropriate and with patients so they understand the personalised care plan. Care plans to also include clear instructions for anticipatory medications such as recurrent respiratory infections, recurrent urine infections etc.

Diagnostics to support diagnosis and on-going management such as phlebotomy/urinalysis etc for patient on the community caseload or who have been referred for assessment.

Medication reviews – medication reviews to be undertaken according to the patient need and these will be communicated to other key services involved in the patient journey as appropriate.

Admin and data support
Underpinning the work of the integrated care teams, the provider must have a support function to provide administration and data support to ensure clinician time is utilised effectively and aid integrated working.

Conditions managed:

Long term conditions
Long term conditions to be managed in a community setting, to include injection therapy, either short term eg anticoagulation, and/or long term therapy eg insulin/B12. This is not exhaustive and will encompass future initiatives within service improvement across the community and acute sectors.

Community geriatrician
Working with closely with the community geriatrician as an integral part to the integrated team and will be used as a resource to manage complex patients as well as provide opportunity for sharing best practice, teaching and education, this includes support in MDTs. Community team will use this service for specialist advice & support.

Care home support
Working closely with care home staff to improve the confidence of staff and jointly proactively identify and manage deteriorating health including end of life care in order to reduce avoidable unplanned admissions. This is achieved through supporting 'bite sized' training as identified by care home staff and community staff. The service will be supportive

with specific initiatives in conjunction with Primary Care to reduce avoidable hospital admissions

End of Life

Adopt overarching end of life principles across all the services, so patients are identified early, care plans are agreed and end of life care supports a dignified end of life. Patients are identified as appropriate to the 'gold standard framework' and discussed at the GSF or other appropriate meetings. To ensure anticipatory medications are available in a timely manner. To support patients, carers and significant others to provide holistic, end of life care in a compassionate, dignified way. The provider will work with other organisations to ensure a dignified end of life so patients and relatives feel supported e.g. Hospice at home.
The provider will support patients in their preferred place of death. Continuing Healthcare will be utilised when appropriate.

The provider will ensure that a Community Macmillan Specialist Cancer and Palliative Care Service is provided consisting of Community Macmillan Nurses who provider care to cancer patients from the point of diagnosis. They will support patients and their carers, to prevent unnecessary hospital admissions from the point of diagnosis through to death, including carer support and following bereavement where these needs cannot be met by other low-level bereavement services and normal grief reaction.

The service shall provide support, training and education sessions 'teaching clinics' to all practices in Nottinghamshire County (south). A named Community Macmillan nurse will be assigned to each practice and will be responsible for ensuring that practices access the support required.

Specialist continence

An assessment, treatment and management function for people who have bladder and/or bowel problems. This includes education, advice, support and clinical practice development in continence for carers and healthcare professionals within the wider health community. A home delivery service will also be available for incontinence pads to people in their own homes, residential and nursing homes

The Provider will adopt a proactive approach to continence promotion by providing a holistic service that includes:
Clinical care to all patients over the age of 18 years within the south of the NHS Nottinghamshire County
Education, support, advice and practice development to all healthcare professionals within primary care, secondary care, social services, independent sector and care homes
Develop and implement evidence based guidelines and protocols
Budgetary management for the home delivery service (incontinence pads delivered to the patients home or care home)
Develop & monitor a continence appliances formulary ensuring standardisation of quality, cost effective products that need to be utilised within all areas.

1.5 Expected Outcomes including improving prevention

All patients over the age of 18 for south of Nottinghamshire County patients, who have bladder and/or bowel problems, will receive a holistic and individual assessment, appropriate treatment and management of their continence problem.

All carers and healthcare professionals within the whole health community who care for a person with bladder and/or bowel problems will have access to specialist education, advice, support and clinical practice development in continence care.

There will be an effective and efficient home delivery service for the provision of incontinence pads to people in their own homes, residential and nursing homes.

Specialist tissue viability
To provide specialist wound care advice for the assessment and management of any patient with healing problems. Specialist staff will provide advice to patients and the staff caring for them on an individual basis to promote wound healing and prevent deterioration or recurrence.

The Tissue Viability service will;

- Provide expert advice and support to healthcare professionals involved in all aspects of tissue viability and wound care.
- Provide specialist assessment and advice on complex and non-healing wounds, or wounds with an unusual aetiology Be responsible for the provision of specialist therapies i.e. topical negative pressure, larvae and wound debridement, including specialist therapies funded by continuing care.
- Provide telephone advice during office hours.
- Assess patients and provide pressure relieving equipment via the Integrated Community Equipment Store
- Advise the Integrated Community Equipment Store on the acquisition of pressure relieving equipment and strategies for the management of pressure relieving equipment.
- Provide professional advice regarding the investigation of complaints, incidents and safeguarding involving Tissue Viability related issues. To work with the systems team to develop a system to support pressure ulcer incidence data collection.
- Undertake Continuing Care assessments for pressure relieving equipment, including reviewing patients as necessary.
- Confirm and challenge decision making on all stage 3and 4 pressure ulcer Root Cause Analyses within community services
- Advise pharmacies and supplies departments regarding the acquisition and management of wound care products
- Develop / implement and regularly review policies, protocols, formularies, documentation and guidelines
- Undertake research and clinical audit relevant to the continuous development of the service.
- Operate a Tissue Viability Link Nurse system, running full day study days 3 times a year and a conference as appropriate
- Be responsible for delivering monthly in-service training packages on all aspects of tissue viability to registered and non-registered staff.
- To deliver a Tissue Viability service in line with national frameworks, local trust policy and commissioning requirements.
- Confirm and challenge decision making with Suspected Deep Tissue Injuries and ensure accurate reporting once status is established
- Manage the ‘alert’ process across the patient pathway to ensure ownership of the pressure ulcer by the relevant provider
- Provide three half days a year of tissue viability training to private nursing homes within the south of the county
- Provide detailed reports for HM Coroners office, as requested utilising specialist nursing expertise
- Monitor numbers and healing rates of PU damage and determine actions to reduce these.
- Work with other providers where PU damage is related to patient pathway spanning organisations to determine improvements and learning to avoid future reoccurrence.

Therapeutic Rehabilitation

- **Primary care rehab**

Identify specific 'hot spots' where support and education to local primary care teams, general practices and care homes would contribute to a reduction of falls. Provide expert advice and support to Primary Care staff, community staff, care homes and home care staff to embed "falls are everyone's concern". Provide falls training and embed the 'prevention of falls' action tool within all community services. Undertake a multidisciplinary assessment and treatment aimed at preventing future falls. Liaising with other key stakeholders as needed and identify how service intervention has reduced risk of falls.
This includes support for neuro-huntingdons patients.
There is expected to be no waiting list due to the effective triage processes.

- **Therapeutic re-ablement at home**

A multidisciplinary assessment and treatment aimed at promoting rehabilitation and independence.

Please refer to the Short Term Health and Social Care Rehabilitation Services Model for a full overview of all levels.

Level 1 (includes high, medium and low levels of need):
Provides services for people in their own home. These services will deliver in partnership with other providers and services independence training for people across a spectrum of needs from low level to high levels of Rehabilitation.

Staff will differentiate in goal planning between 'doing for' and 'doing with' to ensure the person achieves their goals as identified in personalised care plans.

People will receive Care from staff that has been Specifically trained by rehabilitation and Reablement specialist Occupational Therapy trainers and deliver rehabilitation plans and goals under varying levels of oversight from specifically trained rehabilitation therapists.

The services will then be delivered to meet a range of people from low levels of needs requiring only minimal interventions in assistance with washing, dressing and undertaking basic self-care tasks essential to maintain the lowest possible level of dependence upon other services and designed to maximize people's ability to regain their original levels of independence.

Services will then be delivered up to higher levels of care which require significant interventions to support people with complex conditions. These people are likely to have limited mobility to transfer and/or night time needs which may require a range of more intensive nursing, rehabilitation and specialist OT/Physio therapist support to achieve the highest levels of independence attainable within the shortest period possible and no longer than 6 weeks.

Community based rehabilitation within a person own home will be:

- Managed by primary care, community services and providers working collaboratively
- Range in degree of professional oversight from low levels of needs from unqualified rehabilitation support staff to qualified therapist and nursing practitioners.

As soon as their goals have been met even if this is sooner than initially predicted.

- Or if their condition deteriorates and their needs increase and cannot be met within the agreed rehabilitation and assessment period
- People may also have an increased level of need but remain with the service as the revised goal plan for rehabilitation can still minimize the levels of ongoing care they are likely to need.

Levels of qualified staffing interventions will therefore be flexible across the services to meet the range of levels of needs Moderate intervention for more complex conditions means but with additional OT oversight of goal planning and training for the person and to assist Reablement Workers on problem solving. May require some additional nursing, OT and/or Physio input to support the person to achieve independence.

People will clearly decrease in the levels of needs that they present with on a daily basis and be subject to a constant assessment and review process individually tailored to ensure that people are exited from the service:

Low level will be comprised of:

- Independently mobile
- Mobile with minimal aids and adaptations
- Struggling to manage basic personal hygiene tasks following fracture / surgery
- Struggling to dress following fracture / surgery
- Lack of confidence managing independent living following a fall / illness and needing to re-establish confidence
- Disorientation and anxiety of independence living following hospital admission / illness and needing to be re-established at home through support and oversight of basic independent living tasks

Medium level will be comprised of:

- Needs 1 to transfer
- Mobility needs improving and may not improve longer term but assessment is needed of improvement and relevant aids and adaptations
- Unable to independently manage basic personal hygiene tasks following fracture / surgery
- Unable to dress following fracture / surgery
- No confidence managing independent living following a fall / illness and needing to re-establish confidence
- Severe disorientation and anxiety of independence living following hospital admission / illness and needing to be re-established at home through support and oversight of basic independent living tasks
- May also need some nursing interventions for medication and / or dressings / IV pegs etc.
- May need physio / OT therapy input

High level will be comprised of:

- Needs 2 to transfer or is immobile
- Needs period of ongoing assessment to provide appropriate level of ongoing aids and adaptations
- Unable to manage basic personal hygiene tasks following fracture / surgery
- Unable to dress following fracture / surgery
- No confidence managing independent living following a fall / illness and needing to

re-establish confidence

- Disorientation and anxiety of independence living following hospital admission / illness and needing to be re-established at home through support and oversight of basic independent living tasks
- Needs higher levels of nursing interventions for medication and / or dressings / IV pegs etc.
- Needs physio therapy input and other specialisms SALT / OT etc.

Assessment Process:

The assessment process for each service area MUST be compatible with other provider areas and delivered in the same manner to reduce the need for assessments to be re-done to deliver the same outcomes or a continuation of outcomes.

Services will ensure that the assessment process, tools and training is clearly linked to enable transitions to occur between services without duplicated assessment occurring or a change in the approach to rehabilitation or outcomes

Specialist Nursing:

See appendix for further supporting information.

The provider must work alongside secondary care to reduce hospital admissions and to support hospital transfers, and support greater communication between the specialist wards and the community.

All referrals to be actively triaged to ensure appropriate, efficient utilisation of services and ensure services are 'wrapped around' the patient according to patient needs. Actively engage and promote horizontal and vertical integration with mental health services for older people.

Heart Failure
Patients with confirmed heart failure to be case managed by specialist heart failure clinicians within the community if appropriate to reduce hospital admission maximise self-care and self-management and recognise worsening symptoms utilising personalised care plans to prevent exacerbations and ultimately preventing premature death. Provide case management for patients who have a confirmed diagnosis of heart failure, to include medications optimisation, personalised care planning, cardiac rehabilitation, telehelath, effective dietary advice, crisis avoidance and supported discharge The heart failure service will support vertical integration with secondary care, and horizontal integration with the wider community teams, local authority, primary care and voluntary care services. To maximise service delivery, the heart failure service will be delivered within clinic settings as well as via domiciliary visits. Where there is deemed to be limited impact from this service, due to patient condition, referral on to more appropriate services e.g End of Life/community nursing teams for pressure ulcer avoidance.

Respiratory
Patients with known respiratory disease to be managed by specialist respiratory clinicians within the community to reduce hospital admission, maximise self-care and self-management and recognition of worsening symptoms utilising personalised care plans to prevent exacerbations and ultimately preventing premature death. Provide case management for patients who have a respiratory disease, to include utilisation of rescue medications where appropriate, medications optimisation, personalised care planing,

pulmonary rehabilitation, telehealth, crisis avoidance and supported discharge The service delivery will also include the home oxygen service and annual review for patients predominantly with respiratory disease, but also patients how receive home oxygen for other long term and/or life limiting conditions. The respiratory service will support vertical integration with secondary care, and horizontal integration with the wider community teams, local authority, primary care and voluntary care services. The respiratory service will be delivered both in clinic settings and through domiciliary visits, supported by a respiratory consultant.

Diabetes
Patients with confirmed diabetes to be managed by practice teams/community teams within the primary care setting with the support of specialist diabetes clinicians. The outcomes are a reduction of hospital admission rates, maximisation of self- care and management and utilisation of personal care plans to help reduce the risks of long term complications and premature death associated with the disease. Medication optimisation, referral to appropriate support services and personalised care planning will be an integral part of this service

The service delivery will include supporting practice nurses and GP's and upskilling them to a level which enables delivery of high quality diabetes care to all patients with type 2 diabetes. This service will primarily be delivered within the GP practice clinic setting but via domiciliary visits as and when necessary to certain individuals.

The Diabetes Specialist Nurse (DSN) will be expected to support the follow up of patients identified as at risk of further hypoglycaemic events (as per EMAS hypoglycaemia pathway) when the practice staff are unable to deal with this themselves.

Transition from Children's to Adult services:

The service will work in partnership with Children's and Adult commissioners, the Nottinghamshire Integrated Community Children and Young People's Healthcare (ICCYPH) Service and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring support specific to this service specification to ensure seamless continuity of care during transition from children's to adults services.

Proactive planning and care pathways will be developed in line with local and regional transition guidance and the Together for Short Lives transition care pathway (http://www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework that can be adapted locally to plan services specifically for teenagers and young adults with life threatening, life limiting or complex medical conditions. The pathway sets out six standards that should be developed as a minimum, with the aim of achieving equality for all young people and families, wherever they live.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young adults during and following transition
- Use of Nottingham ICCYPH Programme Families' Statement of Expectations (http://www.mansfieldandashfieldccg.nhs.uk/attachments/article/136/ICCYPHP%20FINAL.pdf p.22) as guiding principals
- Continuation of the personalisation approaches and systems used by the young person/adult
- Statutory duty to contribute to and provide services to young people/adults within

Education Health and Care Plans (EHCP) up to age 25 in line with SEND legislation (http://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014)

- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions (http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx)
- Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Networks. Further work is being undertaken locally regarding this document and therefore should not be seen as definitive guidance.

3.3 Population covered

- All patients registered with a General Practitioner in Nottingham North & East, Nottingham West and Rushcliffe
- The age of 18 years.

3.4 Any exclusion criteria and thresholds

- Residents below the age of 18 years.
- People not registered with a General Practitioner in Nottingham North & East, Nottingham West and Rushcliffe

3.5 Interdependence with other services/providers

- Primary care services
- General Practice
- Secondary Care services
- East Midlands Ambulance Service
- Nottingham Emergency Medical Services
- Care Homes staff
- Any locally determine providers
- Local Authority – social services and care agencies
- Mental Health Services
- Medicines management teams
- Red Cross (CiCSS)/Crossroads
- Third Sector Organisations
- Voluntary sector
- Patients, Carers, Relatives.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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

4.3 Applicable local standards

4.4. Workforce

Workforce model

Each Adult Community Care Team will be led by a locality clinical lead and have a mixture of registered nurses, occupational therapists and physiotherapists at a range of skill levels and with varied specialist skills as required to deliver the outcomes of the service. These

staff will be supported by a workforce of unregistered community support workers and assistant practitioners.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

References:

(1) http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_084294

(2) NHS Midlands & East Ambitions. 2012 http://www.midlandsandeast.nhs.uk/OurAmbitions/Everycontactcounts.aspx

(3) The NHS Outcomes Framework 2012/13. DH 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/134662/dh_131723.pdf.pdf accessed 7.5.13

Appendix 1 - Supporting information

Heart Failure

Aims

To provide a community heart failure nursing service, taking into consideration the NHS and Social Care Long Term Conditions Model. The aims of the service are to provide patients who have a confirmed diagnosis of Left Ventricular Systolic Dysfunction with evidenced based care:

- Assessment and management of clinical status
- Assessment of cognitive state
- Lifestyle assessment including nutrition and exercise/rehab
- Pharmacological management
- Support and education for both patients and their carers and healthcare professionals
- Palliative care
- Clinical and peer support for the Community Heart Failure Nurse

Objectives

- Reducing recurrent hospital stay
- Improving clinical outcomes by slowing down the rate of disease progression
- Prolonging life and improving quality of life
- Improving management of cognitive state
- Increasing patient choice
- More efficient service – clearer pathway
- Providing care in the community
- Reducing impact on secondary care and subsequently, 18 week wait

Service description/care pathway

- The service will cover the registered population of Nottingham North and East CCG and Nottingham West CCG
- It is expected that the service will be supported in the patient's home and community clinics and as such, will require daily travel throughout the region of NNE and NW
- It is the responsibility of the provider to secure premises from which the Community Heart Failure Nurse will work.
- The initial paper-based review will be updated from the QOF Heart Failure register to establish patients who have had an echo and a confirmed diagnosis of Heart Failure with LVD. From this, the cohort of patients who will benefit from a heart failure nursing service will be identified.
- The nursing services are to be delivered full-time over 37.5 hours/week. Exact hours to be flexible according to meeting the cluster need and a pro-active approach to care.
- Clinical and management supervision is to be provided by the Provider, including on-going training and development. It is recognised that the clinical supervision may require the Provider to sub-contract with secondary care.
- Provider to offer a fully qualified nursing service including BHF adoption, Caledonian and Non-Medical Prescribing.
- In NNE the service will liaise closely with
    - The Adult Community Care Team
    - The Single Point of Access for adult community services
    - The Primary Care Prescribing Advisers

Service Model

- The service will assess and treat patients through individualised care planning in relation to:
    - Patient Education (self-management)
    - Weight , blood tests, BP and heart rate
    - Diet
    - Titrating Medication/Prescribing
    - General Health Status (physical and psychosocial)
- Care is to be pro-active and intensity and frequency is to be dependent on whether the patient is high or low risk, where they are within their care regime and whether asymptomtic or symptomatic.
    - Defining low risk patients as – knowledgeable about their condition and treatment, compliant with medication and diet, receiving adequate social support, not in need of changes.
    - High risk patients are – poor understanding of their condition, a history of recurrent admissions, poor compliance with medication and diet, inadequate social support, unsuitable lifestyle.
- Care is to be provided through a combination of telephone, home visits and clinic based care. Dependent on status, scheme of care should include a combination of:
    - First contact with 24 hours of receipt of referral and initial home visit within 72 hours
    - Weekly home visits for the first month
    - Visits at 2-4 week intervals
    - Weekly and monthly phone calls to reassess status
    - Community Clinic Assessment
    - Regular evaluation as to whether home visits to be extended
    - Re-evaluation is to be carried out if patient is readmitted to hospital
- Patients are to be regularly reassessed and the amount of follow-up increased or reduced based on their clinical and psychosocial status.
- The HFN is to work towards maximising the impact of the intervention and limiting contact thereafter
- The HFN will only care for patients with a diagnosis of LVD by echo. Therefore, as mentioned above, a paper exercise will be carried out to determine the cohort of patients who have a confirmed diagnosis, what their status is, and from those, who will benefit from heart failure nursing services. The results of the review to be fed back and discussed with relevant GPs and a care plan established.

Care Pathways

- Implementing a Community Heart Failure Nurse Service allows NNE and NW to continue care outside of a hospital setting. The role has been evidenced as an integral part of the pathway, contributing to a multi-disciplinary team approach and reducing the financial burden.

- When a patient is identified as being in end stage heart failure, it is expected that the Community Heart Failure Nurse will link into the End of Life Pathway.

Respiratory

Aims:

The Respiratory Service is a community focused specialist service dedicated to supporting patients suffering with chronic respiratory disease, with a predominant focus on Chronic Obstructive Pulmonary Disease (COPD). COPD is a major cause of morbidity and mortality, approximately 1 person dies every 20 minutes – approximately 25000 people a year (DH 2011).

The service is also responsible for providing reviews for individuals who have been prescribed oxygen therapy, in line with a locally agreed pathway of care. This entails developing effective working relationships with primary and secondary care to maintain a database of information relating to recipients of oxygen therapy. This role is to encompass all adult patients receiving home oxygen, including those with non-respiratory diseases.

The service will enhance the quality of care to patients to reduce unnecessary admissions to hospital, facilitate early discharge and improve optimal medication therapies.

For the purpose of this specification, it will include COPD.

Objectives:

- To proactively seek patients with COPD by working closely with GP practice teams, utilising predictive risk tools.
- To provide a domiciliary specialist nursing and physiotherapy service to people with COPD.
- To deliver integrated, co-ordinated and accessible services for patients with COPD in a cost effective manner, as part of the virtual community ward. .
- To raise awareness of evidence based practice through the provision of training, educational programmes and supervised practice to other community based care providers.
- To provide disease specific case-management including a robust plan of care that is developed in partnership with the multidisciplinary team and which is appropriate to the individual's needs.
- To ensure patients and their carers are equipped with the knowledge necessary to facilitate effective self-management of their respiratory condition within the community setting, reducing the need for acute management and admissions to hospital.
- To acknowledge the palliative stage of the disease process, co-ordinating care to facilitate end of life choices, involving other members of the community ward and multi-professional team as needed.
- To establish and maintain effective channels of communication across the primary and secondary care interface and to forge strong working partnerships with external agencies supporting the patient care pathway.
- To develop and support the implementation of nurse led community based clinics, exercise programmes and support groups such as Breath Easy Nottingham and their carers.
- To identify carers and signpost to appropriate services.
- To avoid admission to hospital, through timely and responsive, evidence based care and optimisation of treatments.
- To provide an evidence based, comprehensive, multi-disciplinary pulmonary rehabilitation course to patients with COPD and bronchiectasis.
- To assist with secondary care early discharge programmes for patients with COPD who can be managed in a community setting with the assistance of a professional multidisciplinary care team.
- To work effectively with smoking cessation services to promote smoking cessation.
- To assist with the delivery of consultant led community based COPD clinics.
- To provide a domiciliary home oxygen review service in conjunction with Nottingham University Hospitals to all patients registered with a Rushcliffe GP on home oxygen, in line with the agreed

care pathway for oxygen therapy. This includes patients prescribed home oxygen for reasons other than respiratory conditions.

- To input and contribute to the HOS-AR portal which will maintain a database of people receiving home oxygen within Rushcliffe.
- To review the home oxygen data from the provider and act accordingly to promote concordance and compliance of home oxygen use.
- To initiate withdrawal of oxygen as appropriate and in conjunction with medical support.
- To inform the Oxygen Provider of any deaths to ensure the equipment is removed from the deceased home and charges to the CCG are stopped
- The objectives will be jointly reviewed with public health patient data, patient population need and development of the respiratory team.
- To contribute and utilise data, local intelligence and national information to inform local service improvements.
- To raise the profile of the CHP respiratory team within the CCG and Nottinghamshire.

Expected Outcomes:

There are recognised limitations in extracting data for specific cohorts of patients e.g. those with Chronic Obstructive Pulmonary Disease (COPD) confirmed on spirometry and it is therefore difficult to demonstrate that any improvement, for example, a reduction in non-elective admissions or length of stay, is directly attributable to the Respiratory Team Service (RTS).
With appropriate, timely and effective home oxygen assessments, a reduction in the annual home oxygen spend will reduce by 10% over the financial year.

The main measurable benefits of the Service will be qualitative and will include:

- Improved patient and carer satisfaction and experience
- Minimal numbers of patient and carer complaints
- Increased compliance with home oxygen and appropriate prescribing of home oxygen
- An increase in the number of patients who die in their preferred place of death
- Improved satisfaction for wider stakeholders for example, increased GP satisfaction with the consistency and accessibility of services measured against previous survey results.
- To increase the number of patients with personalised care plans.
- To increase the number of patients who have standby rescue medications in the event of an exaccertbation.
- A comprehensive database of patients receiving home oxygen, including diagnosis, HOOF prescriptions, diagnosis etc.
- Data collection and co-ordination of the home oxygen service and patients receiving home oxygen, including those who do not have a primary respiratory condition.
- Provide home oxygen expert advice for patients, relatives, GP, and community colleagues.

Service Description

The clinical focus of the Service is evidence based disease management and promotion of self-care strategies for patients predominantly with COPD. It includes reduced attendance at the Emergency Department or avoidable admissions using a case management approach and the facilitation of end of life care choices for patients with advanced disease. The service will also work to extend and strengthen the knowledge base of respiratory disease management within the community setting so that the capacity to manage patients with stable COPD in primary care is increased, and to reduce hospital admissions unless admission is required for more complex management. The team comprises of Respiratory Nurse Specialists, home oxygen nurse, clinical support workers, Physiotherapy and administrative support but with access to the wider health and social care community to provide services to promote independence and self-management as much as possible.

Referrals to be processed via the Rushcliffe Community Hub and to include the wider multidisciplinary team input including occupational therapy, medicines management, mental health services and community nursing as required.

Service Model

The integrated service model will include:

Level 1:

- General Practice: it is anticipated 70-80% of patients with respiratory disease will be stable and will attend their GP practice. Patients can be referred directly to the pulmonary rehab service by the GP. Members of the respiratory team will review practice registers with GPs, using risk prediction tools to determine any patients who would benefit from review to prevent possible escalation into Level 2

Level 2:

- Patients who require a medium level of case management
- Patients who have a 'pink card' referral initiated by the GP, community matron, secondary care or the respiratory team.

Level 3:

- Patients who are at risk of unplanned hospital admissions through exacerbation and/or who are thought to be 'not stable'.
- Patients who require proactive medications management through anticipatory antibiotics and/ or steroids.
- Patients who require long term oxygen therapy.
- Patients with personalised care plans.

Direct patient care:

A comprehensive assessment and care plan, based on an individual need will be implemented and supported via domiciliary visits and/or clinics.

- Care is provided via home-based visits (including residential and nursing homes), nurse-led clinics or a combination of both. Most patients will have at least one domiciliary visit with the need for further visits or clinic attendance agreed with the Nurse Specialist. Frequency of follow-up is based on the individual clinical needs of the patient.
- The patient's pharmacological management is reviewed and optimised in accordance with evidence based guidelines and in collaboration with the patient's consultant and /or GP.
- Clinical status is regularly monitored and appropriate laboratory parameters reviewed following changes to medication to facilitate early detection of clinical deterioration and/or adverse drug related side effects.
- Pulmonary rehabilitation provided within a suitable environment, e.g. health centre.
- Domiciliary Home Oxygen 4 -6 week reviews for all patients prescribed home oxygen following the initial home oxygen assessment which will be carried out by NUH Respiratory Service, or any other service who initiates (Long Term Oxygen Therapy) LTOT.
- Home oxygen reviews for patients who require a review.

Education and training:

- The emphasis of patient education is upon empowering the individual with the knowledge and skills necessary for effective self-management of their condition.
- The Service provides a specialist educational resource for other community based care providers supporting patients with COPD and/or those who are prescribed home oxygen.

Referral Criteria and Sources

All respiratory patients referred must have spirometry, a recent chest x-ray and/or a diagnosis of respiratory disease i.e. COPD or patients who are prescribed home oxygen

Considerations for referral:

- Patients with COPD who require optimisation of therapies.
- Patients who are on maximal tolerated therapy who require disease specific education to promote effective self-management of their long term condition.
- Patients with a history of unplanned respiratory related hospital admissions.
- Patients in whom symptoms persist or deteriorate despite treatment.
- Patients who would benefit from pulmonary rehabilitation (including bronchiectasis)
- Patients who are prescribed home oxygen excluding palliative care.

Diabetes Specialist Nursing

Background

Diabetes mellitus is a long-term condition in which the body is unable to control blood glucose levels due to an absolute lack of insulin (Type 1) or relative lack of insulin and/ or insulin resistance (Type 2). It is recognised there are two main types of diabetes mellitus – Type 1 diabetes (T1DM) which accounts for approximately 10% and Type 2 diabetes (T2DM) which accounts for approximately 90% but in addition there are other less common types.

The number of people with diabetes is increasing worldwide and in the UK it is projected to rise from current levels of 3.1 million to 3.8 million by 2020 (1). One of the risk factors for T2DM is obesity and due to increasing obesity levels in the UK it is expected that the incidence of T2DM in the UK will increase as a consequence of this to an estimated number of 4.6 million by 2030 (2,3).This makes it the long- term condition with the fastest rising prevalence.

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality of care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year (4). In addition poor diabetes control and management can lead to serious life-threatening and life-limiting complications.

As an individual may also have other long-term conditions in addition to diabetes, the NHS needs to rise to the challenge of multi-morbidity through proactive and comprehensive disease management, placing the individual firmly in the centre of the care. It does, however, need to be acknowledged that not all people with diabetes have additional long term conditions but they too require access to good quality care provision.

Whilst it is acknowledged that many of the service requirements for T1DM and T2DM will overlap – such as retinopathy, podiatry, psychological therapies etc. there are differences between the two groups and as such the service provision and delivery need to accommodate these differences. It is still generally considered that patients with poorly controlled T1DM and young adults are best managed by secondary care teams along with the other specialist groups including those with severe renal disease, foot problems, patients on insulin pumps as well as pregnancy and inpatients (5).

Within Rushcliffe CCG the GP practices currently choose to deliver an enhanced service for patients with type 2 diabetes at one of three levels. The majority in Rushcliffe deliver a Level 2 service with only 3 practices choosing to deliver a Level 1 service. There are no Level 3 practices.

The level of support that practices require from the DSN service varies according to the expertise and confidence of the practice staff but also to the number of patients with type 2 diabetes within the practice.

As the number of people with diabetes is increasing annually the Provider will need to take this into account when designing their delivery model to ensure that all outcome measures are maintained for the duration of the contract.

References

1. The management of adult diabetes services in the NHS – National Audit Office; 2012 in POSTNote Number 415 Preventing Diabetes , July 2012
2. Commissioning Excellent Diabetes Care: an at a glance guide to the NHS Diabetes Commissioning Resource – NHS Diabetes and Diabetes UK, February 2012, second edition

3. Diabetes in the UK 2009: Key statistics on diabetes, Diabetes UK 2009
4. National Diabetes Audit Mortality Analysis 2007–2008 - NHS Information Centre 2011
5. The Super Six Model of Diabetes care: Two years on. Diabetes & Primary Care Vol 15 No 4 2013

Previous commissioned service

Historically diabetes services were mainly delivered in secondary care clinics, especially for people requiring complex management including insulin. In 2010, a diabetes service was commissioned by Rushcliffe CCG (formerly Principia Partners in Care) which allowed for the avoidance of referral into secondary care clinics for insulin initiation and the transfer of patients back to GP management for those patients with T2DM on insulin therapy. By having the support of an experienced Diabetes Specialist Nurse (DSN) and a secondary care consultant providing mentorship for the DSN, the GP practices felt adequately supported to safely deliver this service. The purpose of this service was to provide a locality based, high quality, patient centred service which was delivered by practice teams at different levels according to levels of experience and expertise within each GP practice. The service levels were agreed by each practice and the levels reflected the amount of help and support needed from the DSN.

Level 1 DSN led clinics (minimal practice involvement) to a specific cohort of patients. This is the only level where the DSN had a caseload and patients remained the responsibility of the Provider (Nottingham University Hospitals NHS Trust).

Level 2 DSN/GP practice would deliver joint specialist diabetes clinics (sharing of responsibility between GP practice and Nottingham University Hospitals NHS Trust)) to any patient with type 2 diabetes who they felt they needed help with or required complex treatments such as amber 2 drugs (oral and injectable therapy) or insulin.

Level 3 GP practice would manage patients with type 2 diabetes on their own (minimal DSN involvement).

There was a financial remuneration for those providing either Level 2 or 3 services at a pro- rata rate for different levels and the service provided –

1. For insulin initiation
2. Management of patients with T2DM on insulin.

(No financial remuneration is given to Level 1 practices).

This service was primarily for people with T2DM but on occasions accommodated patients with T1DM. These tended to be individuals who refused to attend secondary care for their diabetes management.

Aims and Objectives

The provider shall:

- Provide and support the delivery of high quality care, as defined by NICE Quality Standard (Q56), to all service users
- Provide and support the delivery of a holistic approach to the management of diabetes for all service users
- Support the use of personalised care planning for each service user which will form the basis of their management and self- management.

- Empower the service user to self-manage their diabetes and encourage independence when possible and appropriate
- Contribute to helping reduce the risk of morbidity and mortality arising from diabetes by practicing evidence based medicine
- Contribute to reducing the severity and frequency of acute episodes and helping to avoid unnecessary admissions to hospital for diabetes related problems
- Ensure that service users are referred to appropriate services as and when a specific clinical need arises
- Offer support and advice to the service user directly or through the relevant health care professional (HCP) to help with their diabetes management and achieve an improvement in glycaemic control when needed.
- Support other HCPs to provide regular and ongoing monitoring and assessment of the person with diabetes
- Provide education to HCPs as necessary to support professional development

Service description/care pathway

- The service will cover the registered population of Rushcliffe CCG
- The service will mainly be provided within General Practice (GP) surgeries but can be in the patients home if deemed more appropriate
- It is the responsibility of the provider to secure premises from which the DSN will work
- The CCG have commissioned a full time DSN for Rushcliffe. The DSN service will ultimately be delivered over 37.5 hours per week, however, due to current resources it is only possible for it to be delivered Monday to Thursday (30 hours per week). Exact working hours need to be flexible to accommodate the requirements of the practice and the service user.
- Current resources do not allow for cross cover across different CCG's and the service cannot accommodate any emergency cover
- Referrals will be through the community single point of access (SPA)

Service Model

Good standards of diabetes care needs to be delivered by all HCP and all practices. In order to optimise diabetes care to the majority of patients with T2DM the DSN service needs to position itself within primary care and work closely with all GP practices within the CCG. As such the service will primarily be a practice- based service but there will be support for allied HCP within the community when necessary.

	Level 1 (Specific caseload)	Level 2 (No caseload)	Level 3 (No caseload)
Support the initial and continuing assessment and management of the service user with diabetes with sub-optimal control	The DSN would require a written referral from GP practice with a clear reason for referral. If patient is not on injectable therapies/specialist medications the patient should be discharged back to practice management once stable	The GP practice would book patient into the joint specialist diabetes clinic for a review with DSN. If practice team feel able to manage patient with support they will take over responsibility for ongoing management	No DSN support should be required. If necessary GP practice can discuss the case with the DSN via telephone.

Support regular care planning for each service user with diabetes. This personalised care plan should be used in all care settings that the service user attends	The practice is responsible for performing the annual review for diabetes/long term conditions. Personalised care planning should be performed as part of this yearly review.	The practice is responsible for performing the annual review for diabetes/long term conditions. Personalised care planning should be performed as part of this yearly review.	The practice is responsible for performing the annual review for diabetes/long term conditions. Personalised care planning should be performed as part of this yearly review.
A responsive service is provided that addresses practice and service user needs, provides support and demonstrates that feedback is acted upon and informs improved service delivery			No DSN support should be routinely required unless in exceptional circumstances. When needed telephone support should be available to the practice staff
The provider will triage all referrals following the agreed referral pathway. If the requirements of the service user are beyond the scope of the service the provider will ensure fast track referral into the specialist pathway	Referral pathway to be clarified and criteria agreed	Referral pathway to be clarified and criteria agreed	No DSN support should be routinely required unless in exceptional circumstances. When needed telephone support should be available to the practice staff
Provide continuing diabetes education to practice staff and community staff			
Assess and support the clinical competency of staff providing diabetes care			
Provide informal education for service users in all settings to promote self-management	This forms part of the consultation and will be given as required based on patient need	This forms part of the consultation and will be given as required based on patient need	No DSN support should be routinely required unless in exceptional circumstances
Support the CCG Medicines Management team to review prescribing guidelines and practice	Regular meetings between DSN and Medicines management leads to facilitate this	Regular meetings between DSN and Medicines management leads to facilitate this	Regular meetings with practice staff and medicines management leads to facilitate this
Partake in and lead audits across all care			

settings, reviews data and uses it to inform and stimulate improvements in service delivery			
The provider will update GP practice systems detailing interventions and treatment plans to ensure effective communication within primary care	The DSN will update patient record during consultation as will be using practice based system (not community model) Telephone consultations can be entered remotely onto SystmOne but not on EMIS web system	The GP/PN will update patient record during consultation as will be using practice based system (not community model) Telephone consultations can be entered remotely onto SystmOne but not on EMIS web system	The GP/PN will update patient record during consultation as will be using practice based system (not community model)

Ad hoc

- Signpost service users to local accredited structured education program DESMOND
- Signpost service users to other services e.g. Changepoint, Fit4Life programme
- Encourage patients to attend local retinopathy screening service
- Arrange for GP practice to refer to specialist services e.g. psychological support, foot services, pre pregnancy counselling services

Referral Criteria

- The service will be locally based with the majority of the care provided in GP practices across the CCG locality. The majority of patients with T2DM (with occasional T1DM) will be managed through local GP practices with the support of a DSN and consultant diabetologist.
- Patients with compliance issues or a need to consider a therapy change (which the practice feels unable to do themselves) should be referred to the DSN/joint specialist diabetes clinic.
- Patients requiring commencement of insulin therapy/non- insulin injectable therapies where the practice is not confident/competent to do this independently should be referred to the DSN/joint specialist diabetes clinic.
- Patients with complex care needs/complex medical history which the practice staff feel unable to manage themselves should be referred to the DSN/joint specialist diabetes clinic
- Patients with suspected newly diagnosed type 1 diabetes should be referred to NUH drop in clinic/same day clinic as an urgent/emergency referral