

## A.

<b>Service Specification No.</b>	04/GMS/0005
<b>Service</b>	Locality Community Care Teams, Bournemouth and Poole
<b>Commissioner Lead</b>	CCP for General Medical & Surgical
<b>Provider Lead</b>	<i>Norma Lee</i>
<b>Period</b>	2013 /14
<b>Date of Review</b>	<i>To be agreed</i>

### **NHS Outcomes Framework Domains & Indicators**

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

## 1. Purpose

### 1.1 Aims

The service will identify people with long term conditions and will provide them with access to a range of services which are personalised to meet their needs. They will be supported by services which promote self management, health and well being, independence, reduce the exacerbation of their long term condition, and prevent unnecessary use of hospital or specialist services, and supporting timely effective transfer from hospitals to community services.

People who have complex long terms conditions and are very high intensity users of hospital and specialist services will be supported by this service through a process of systematic case finding using agreed case finding tools and a process of case management by Locality Community Care Teams

### 1.2 Evidence Base

The commissioning intentions set out in this specification have been informed by the Transforming Community Services Strategic Commissioning Plan submitted to the Strategic Health Authority in October 2009.

The plan was informed by the following national guidance:

The final report of the NHS Next Stage Review, '*High Quality Care for All*'<sup>1</sup> sets out the strategic direction for driving improvements in the quality of care across the health service.

'*Our vision for primary and community care*' draws together the main conclusions of the Next Stage Review for community-based NHS services, including GP services and sets out a strategy based around four key areas:

- shaping services around people's needs and views;
- promoting healthy lives and tackling health inequalities;
- continuously improving quality;
- ensuring that change is led locally.

Our health Our Care Our Say sets out a vision to provide people with good quality social care and NHS services in communities where they live;

Transforming Adult Social Care and the Putting People First Concordat heralds a strategic shift towards personalisation, early intervention and prevention in adult social care. This means every person, whatever their need, having choice and control over the shape of his or her support, in the most appropriate setting. Central to this policy is the development of individual budgets for social care clients. Providers of community health services need to adapt their practices so that they can respond positively to social care clients who choose to spend some of their budget on health care services;

New Framework for LAAs designed to strengthen local leadership on health and wellbeing and make it easier for local authorities and the NHS to work together to tackle health inequalities and deliver better services to their local area. It emphasises the importance of joint appointments, pooled budgets and integrating planning cycles.

National Stroke Strategy to modernise service provision and deliver the newest treatments for stroke. This includes the management of vascular risk factors, the development of specialised rehabilitation, carer involvement, long-term care and end of life care, all of which will have implications for the provision of community services;

The National Service Framework for Long Term Conditions sets 11 quality requirements to transform the way health and social care services support people with long term conditions to live as independently as possible. Although the National Service Framework focuses on people with long term neurological conditions, much of the guidance applies to anyone living with a long term condition.

A recipe for Care: not a single ingredient: sets out the plans to reconfigure specialist services to bring care closer to home.

Supporting People with Long Term Conditions sets out the new clinical function of specialist nurses and community matrons.

The National End of Life Strategy sets out the key priorities for improvement in end of life care over the next ten years and is focussed on the care of adults over 18 years of age.

This specification has been informed by national policy in 2010-11 such as The 2011-12 Operating Framework, the NHS Outcomes Framework for 2011-12 and Equity and Excellent: Liberating the NHS.

### **1.3 General Overview**

The Joint Strategic Needs Assessment (JSNA) identified that Bournemouth and Poole, while affluent when taken as a whole and compared with the UK, include large numbers of people living in at the extreme ends of the social scale. Those at the lower end have a health status similar to residents of the least advantaged boroughs in the UK. In real terms this means that there are significant health inequalities across Bournemouth and Poole, with a difference in life expectancy of nearly eleven years between the least and most deprived wards. The percentage of people with long term conditions is higher in areas of social housing.

The risk factors underlying the development of cardiovascular disease, cancer and other chronic diseases have a higher prevalence in areas with higher multiple deprivation scores. For example, the prevalence of smoking tends to be much higher in the most deprived areas of Bournemouth compared with the most affluent areas of Poole. This translates into observed differences in smoking related disease such as cardiovascular disease and cancer. In order to close the gap in all age and for all causes of mortality it is essential that efforts to improve health behaviour are targeted in areas with the highest prevalence of unhealthy behaviours.

The JSNA identified that population and demographic changes will have a significant impact on the demand for intermediate and rehabilitation services. Bournemouth and Poole have similar population structures on the whole, characterised by an older population compared with the England average. The proportion of people aged 60 years and above in Bournemouth is about 25 per cent, while in Poole it is about 27 per cent. This compares with an equivalent figure of 21 per cent for England.

While for the UK as a whole, the over 65s account for 16% of the population, they occupy two thirds of the general and acute hospital beds and account for 50% of the recent growth in long term admissions. Even after age, sex and deprivation standardisation, NHS Bournemouth and Poole have higher than expected emergency hospital admission rates compared to other regions in the South West and nationally.

A number of factors are likely to impact on the demand for community services, the types of service required and the locations in which they should be provided. The impact these population changes are forecast to have on patterns of disease among people aged 65 and over include:

8.5% increase to 28,800 in number of people with a limiting long-term illness;

6.8% increase to 5,400 in people with dementia;

7.9% increase to 1,800 in people with a long standing health condition caused by a stroke;

11.4% increase to 1,500 in people with a long standing respiratory condition.

Data from the Quality and Outcomes Framework for 2008/09 identified that there are 149,237 people on long term condition registers in GP practices. It is recognised that a number of individuals will have more than one condition and will therefore have been counted more than once in these data. The Joint Strategic Needs Assessment 2008 concluded that currently in Bournemouth and Poole:

26,600 patients are living with a long term condition' with a predicted increase of 10% by 2015 approximately 2,600 additional patients;

21,000 patients (80%) require supported self care;

3,900 patients (15%) require complex disease management;

1,300 patients (5%) require complex case management.

Other significant issues to be taken into account in configuring community services include:

people are living longer, having children later and therefore there are larger generation gaps;

more older people are living alone and can feel isolated and cut off from their community;

people with disabilities and long term illness (particularly older people) miss out on opportunities that are open to others;

higher levels of obesity and overweight in the population which have major implications for local health services since obesity significantly increases the risk of all of the main causes of premature mortality and substantially contributes to chronic illness and disability.

#### **1.4 Objectives**

The objectives of the locality community care teams are to:

- provide high quality nursing and therapeutic care and support to clients in their own homes, including care homes, and offer advice to other appropriate community settings
- ensure that people are treated with dignity, respect and kindness at all times;
- provide appropriately trained workforce to deliver the commissioning specification
- provide a locality service providing a full range of services as part of agreed pathways to meet the needs of patients registered with NHS Bournemouth and Poole General Practitioners, in particular for those with short term health and social care conditions, long-term and/or complex conditions, management and care at the end of life including case management of those at risk of admission to hospital;
- ensure generalist palliative care services are incorporated into the care pathway for patients at the end of life;
- provide co-ordinated care across health, social and voluntary care sectors and across care settings using a variety of methods including the single assessment process and working closely with GPs to avoid duplication of care;
- adopt a public health approach to all areas of practice to reduce ill health and promote healthy lifestyles using information on the health needs of local population to inform the skills and knowledge development of the teams;
- provide best practice in relation to self-care; early detection and intervention; proactive and integrated care; specialist care and rehabilitation;

- develop an integrated health and social care locality model for the provision of care to patients particularly those living with a long-term condition;
- provide case management to agreed quality criteria for 'very high intensity users' including the identification, assessment, advice and follow-up, optimal self-care and education of patients.
- provide disease management specialist nursing services for patients with long-term conditions to reduce avoidable hospital or long term care admissions;
- provide evidence based, clinical and cost effective treatment packages (in line with NICE guidance where applicable) working closely with primary, secondary, social, voluntary and third sector care teams in partnership with patients and carers;
- Liaison with inpatient settings to actively plan with ward staff the appropriate and timely discharge of patients;
- ensure people are referred to the most appropriate service in times of need through use of the single point of access;
- work with commissioners to continuously review the quality and outcomes of care providing regular performance and outcomes audit to an agreed schedule.
- Advise care homes to prevent admissions and to maximise functional ability;
- Strong daily links with the Intermediate Care Service to ensure effective liaison and handover for patients, co-case managing when appropriate;
- To link with Older People's Mental Health Teams, through multi-disciplinary team meetings
- Ensure the locality community care teams are trained and competence maintained.
- To undertake anxiety and/or depression screening using PHQ9 or GAD7 as appropriate for patients with a LTC on a caseload (subject to agreement of the revised IAPT/ Talking therapies pathway)

### **1.5 Expected Outcomes including improving prevention**

The high level outcomes for people with long term conditions are:

- people have improved life expectancy, quality of life, health and well-being and are enabled to be more independent;
- people are proactively case managed to reduce the likelihood of exacerbation of their condition and the likelihood of an unplanned admission;
- people have community service alternatives to hospital and care home admission, therefore reducing unnecessary admissions and supporting early hospital discharges;
- people have choice and control over their care and support so that services are built around the needs of individuals and carers;
- people have access to integrated health and social care services which are high quality, efficient and sustainable;
- people will have equity of access to education, support and services appropriate to their condition.
- Personalised Care Plans will be in place that have been individually written and agreed with the patient.
- Identification and referral of carers to social services to prevent carer breakdown
- Patients with home oxygen therapy will be reviewed annually

### **1.6 Case management**

1. Patients for case management will be determined through an agreed case finding methodology using a standardised risk score, in line with the roll out of RISC. This case finding will be done in conjunction with the

primary care MDT.

2. Case managed patients will have, at the least, an annual review.
3. Community matrons are likely to have an active caseload and a dormant caseload of previously case managed patients who are now discharged from an active caseload. Patients on the dormant caseload should have an annual review within the Long Term Conditions Service which is communicated to all relevant health and social care professionals
4. All case managed patients will be actively involved in developing a personalised care plan.
5. All case managed patients will have a copy of their care plan and an individualised information prescription. They will have recorded significant events / issues on their care plan
6. All health and social care personnel involved in the patient's care, including the GP, will have access to a copy of the up-to-date care plan
7. All case managed patients will have their goals recorded and will show improvement in their most important goal areas
8. All case managed patients will know the contact number/names to contact when they have concerns that could lead to an emergency admission
9. All case managed patients who are dormant or have been discharged from the scheme will know how to self-refer themselves when they have concerns
10. All carers of people with a LTC will have been offered a carers assessment. If it is declined it will be re-offered at least annually
11. All case long term conditions case managed patients will receive an equitable level of provision regardless of
  - a. living in a care home or at home.
12. Co-morbidity of psychosocial problems or memory loss/ dementia with a physical condition
13. Where the patient has a memory loss with possible undiagnosed dementia, the patient will be referred to the memory clinic, following formal consenting procedures. (and/or discussed with the OPMCHT link worker))
14. Where the patient has a memory loss / dementia, they will be referred to dementia-related support services, following formal consenting procedures
15. Community matrons or appropriate representatives will regularly attend MDTs in localities / GP practices to discuss the joint management strategies for their patients and to advise on management strategies for other patients. Health and social care staff also involved in the patient's care feel that the matron's involvement in a patients care is beneficial for the patient.

## 2. Scope

### 2.1 Service Description

The service will be provided by integrated teams made up of Community Nurses, Therapists, and generic support workers, working with general practitioners, domiciliary carers and voluntary sector providers and other partners in each locality.

The service will undertake health promotion activities, promote self care, and systematic case finding and management with planned programmes of care and review to prevent unnecessary use of hospitals, care homes and specialist services.

The service will engage in the development of the use of assistive technology such as telehealth/medicine and telecare to support the effective management of people with long term conditions.

The locality services will provide:

- Auditable and personalised self care and self management approaches to enable individuals and their carers to develop an understanding of how they can manage their condition in the context of their individual lives and how to cope with their symptoms. These can be done in various way most suited for the patient / carer and may include:
  - information and advice about their condition and treatment options;
  - participation in the Expert Patient Programme;

- participation in other structured education courses;
- telephone based health coaching;
- peer support networks;
- psychological support including IAPT;
- access to key workers/case managers;
- buddy system to support patients who are newly diagnosed or require additional support;
- engagement of patients/service users and their carers in the formulation of personalised care plans;
- comprehensive locality based packages of planned care and rehabilitation for people with long term conditions, including respiratory disease, cardiac disease, for example stroke and heart failure and neurological conditions, which will reduce reliance on care home and hospital services;
- falls assessments and services to promote independence and reduce the likelihood of falls;
- effective management of chronic wounds, such as leg ulcers, in line with best practice, including referral onto specialist teams as necessary;
- specialist nursing services for tissue viability to ensure the delivery of best practice across Bournemouth and Poole (only to patients registered with a Bournemouth and Poole GP in the community and patients on Jersey and Guernsey wards);
- a case management service by community matrons or AHPs for those patients with complex co morbidities and/ or long term conditions who are at risk of repeated hospital admission; including those who are receiving continuing healthcare funding
- Effective regular engagement with General Practitioners as key partners within the locality teams for the provision of general medical services, with identified key workers for each practice;
- assessment and management of individuals for the use of assistive technology to manage their health and social care needs and who will either individually or with the help of carers use assistive technology safely and with proper governance and to be involved in pilot use of telemedicine
- medicine review and management plan for each individual to ensure optimisation of treatment plan and effective engagement with pharmacy services;
- effective prescribing practice for equipment services in line with agreed practice;
- To have an active case finding and review mechanism for high risk patients for a matron's caseload. To hold (at least monthly) multi-disciplinary and multi-agency case conferences in primary care surgeries/clinics to review high risk patients which should include GPs from the relevant practices. Where RISC has been introduced, to use this as the case finding and review tool. To include OPCMHT link worker when appropriate. To hold ad hoc multidisciplinary /multi agency case conferences / reviews as appropriate;
- provision or referral for advocacy for patients as appropriate
- Addressing the needs of carers to prevent carer breakdown
- Key worker of patients with long term conditions that are in the palliative stages

## **2.2 Accessibility/acceptability**

The services will be provided in the four local authority localities in Poole and three local authority localities in Bournemouth to all people age 18 years and over, registered with a GP in Bournemouth and Poole and will be accessed through a single point of contact.

- To provide equitable service levels in each locality according to the numbers of people with a long term condition.

## 2.3 Whole System Relationships

The service works closely with:

- Intermediate Care Other community services and community service providers;
- Older People's Mental Health Teams
- Palliative care/End of life services;
- Social care services;
- Primary care services including community pharmacies;
- Acute care services;
- Voluntary care agencies;
- Patient , public and carers;
- Nursing and care homes;
- Ambulance Services
- Primary Care Trusts.
- GPs

## 2.4 Interdependencies

The following agencies directly and indirectly influence the work of LTC team and it will therefore be essential to ensure that systems (subject to funding) are in place to provide good communication and a smooth transition for patients and carers between and across these services:

- GPs;
- Acute care closer to home teams;
- Social services;
- OP CMHT
- Carers;
- Equipment services;
- Community Pharmacies;
- Acute services.

## 2.5 Relevant networks and screening programmes

The following networks and screening programme relating to the service have been identified however this list is not exclusive and other networks and screening programmes may also be identified over time:

**Note: all networks/Local Implementation teams are under review)**

- Long term conditions Local Implementation Teams and the long term conditions accelerated development programme
- Dorset Cancer Network;
- National Service Frameworks networks for Long Term Conditions;
- Pan Dorset Stroke Network Board;
- Pan Dorset Long Term Conditions LIT;
- The National Institute for Clinical Excellence;
- Infection control forums;
- National Service Framework for Older People
- Chronic disease monitoring an screening programmes including venous circulation assessments, diabetes and respiratory disease;
- National Patient Safety Agency.

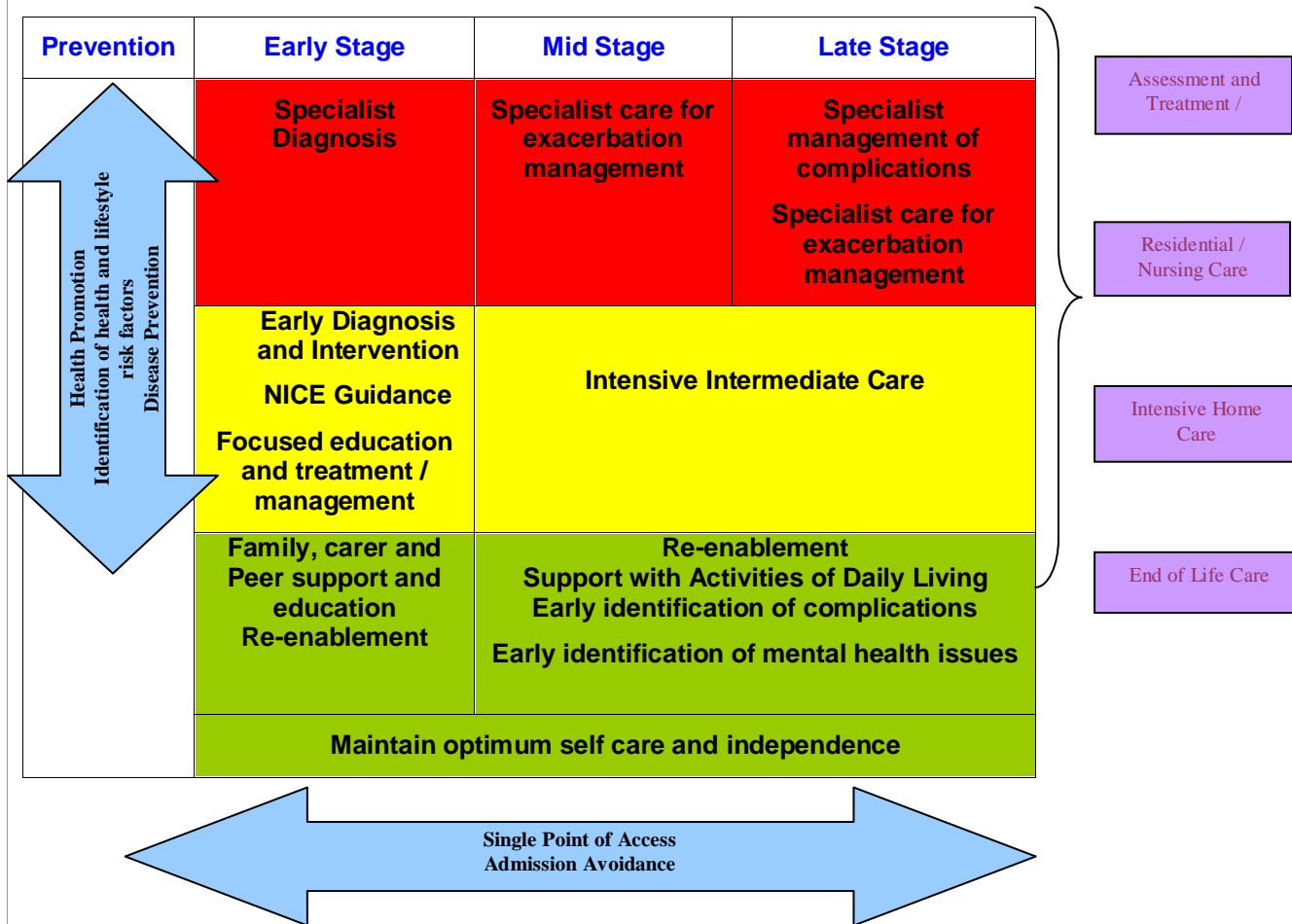
## 3. Service Delivery

### 3.1 Service model

The commissioning plans for the NHS Bournemouth and Poole are built around the concept of services that are

centrally co-ordinated through a single point of access, delivered by locality based teams, and follow a generic care pathway to avoid duplication and delay.

**Pathway - Long Term Conditions Pathway**



The Locality community care teams will be the key worker through all stages of the pathway. Other teams or professionals will support the LTC team if the patient has an exacerbation or condition that requires the specialist care in the short term.

**Early Stages**

Once diagnosed, people will have information, education and support for optimum self care, treatment and management in the community to prevent or reduce the frequency of exacerbation. In some instances, referral to specialist services for diagnosis may be required, however ongoing care will be provided in the community setting where possible. Carers will be supported to help the person remain independent with support from reablement services where appropriate. Support to develop optimal self care will be provided to reduce risk of admission during times of exacerbation of long term condition.

Planned care for people with Long Term Conditions will continue to be provided in peoples own homes or place of residence and other community settings.

**Mid Stage**

When a person’s condition deteriorates, intensive intermediate care will be available (through a single point of access), to support and manage the person in the community. Care will be delivered by an integrated health and social care team, with full clinical intervention as appropriate. This will reduce the need for frequent visits to General Practice or attendance at A&E or the need for admissions to hospital.



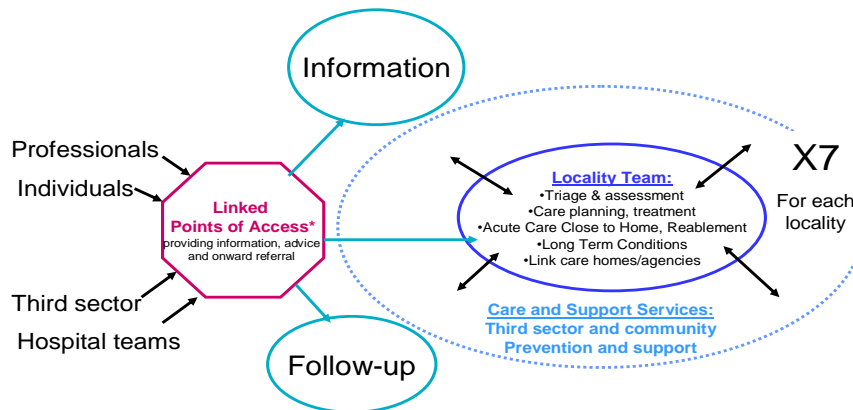
## Late Stage

In the late stages of a chronic disease, where patients need to be admitted to hospitals, the length of stay will be kept to a minimum and once stabilised, case managed in the community with appropriate support.

End of life care following the Liverpool Care Pathway will be provided in the community to support people and their carers at the end of life if this is their wish. This will contribute to the reduction in the number of patients who die in hospital. People will be supported to die in their home or care home (nursing and residential) if this is their wish. The Long term conditions teams will be the key worker for the patient through to the palliative stage, even when other specialist teams may provide specialist advice / support

The locality model of working, and the interdependent links with other statutory and voluntary, and the single point of access, can be represented in the following diagram. This model has been taken from the Older People's Joint strategy

Model of Services for Older People and people with long term conditions



## 4. Referral, Access and Acceptance Criteria

### 4.1 Geographic coverage/boundaries

#### Locality based service delivery

Seven locality areas have been identified; four areas in Poole and three in Bournemouth. For more specialist services wider supra-locality are likely to be more appropriate options to ensure effective and efficient delivery.

Services will be linked to GP surgeries within each locality.

### 4.2 Location(s) of Service Delivery

Within the seven localities and supra localities locations will be identified for co-location of health and social care staff.

### 4.3 Days/Hours of operation

- The service will be provided from 7am -10 pm, seven days a week, throughout the year, achieved through effective working with other community services such as intermediate care services.

#### **4.4 Referral criteria & sources**

Referrals will be accepted from Hospitals, GPs, intermediate care services, CMHTs ambulance service, self referral, social care and third sector and voluntary organisations including care homes and nursing homes.

The referral criteria will support the delivery of the service description and objectives set out in the specification.

#### **4.5 Referral route**

Currently referrals are received in writing, by fax or phone however as the single point of access develops this will be the preferred referral route for all referrals into the integrated long term locality teams.

#### **4.6 Exclusion criteria**

People under the age of 18 years old;  
Patients not registered with a Bournemouth and Poole GP.

#### **4.7 Response time & detail and prioritization**

Referrals should be assessed on the day they are received and triaged appropriately to determine the appropriate response time and appropriate service or professional required.

##### **Urgent:**

Four hours

##### **Non-urgent:**

Contact with the patient within 48 hours to arrange an appointment

## **5. Discharge Criteria and Planning**

Discharge planning will begin when a person enters the service to ensure appropriate support is in place on discharge.

Patients should be regularly reviewed to assess their needs over time and discharge plans adapted accordingly, ensuring services are delivered in an efficient and effective way, maximising the use of resources.

Teams will work with GPs and other health and social care staff as appropriate in planning discharges for patients with complex conditions to avoid duplication and omission.

Teams will also work in an integrated way with acute care closer to home teams for step up and step down care and with specialist palliative care services to fully support patients and carers at the end of life.

## **6. Prevention, Self-Care and Patient and Carer Information**

## Prevention

People will be provided with information, advice, guidance and support in the community to enable them to lead healthy life styles, reducing their risk of getting long term conditions in later life.

People who have health concerns will have prompt access to primary care services to enable early diagnosis.

### Single Point of Access

A single point of access will be provided so people and their carers can access services within the community when a concern is identified or a person's condition deteriorates. The single point of access will provide triage with access to the appropriate health and/or social care services in a timely manner.

The teams will work to establish central information points to ensure consistent, accurate and up to date information is available to all patients and carers to support prevention, self care and self management.

## 7. Continual Service Improvement/Innovation Plan

<i>Description of Scheme</i>	<i>Milestones</i>	<i>Expected Benefit</i>	<i>Timescales</i>	<i>Frequency of Monitoring</i>
Teams will engage in the implementation of the RISC programme	To be agreed within RISC project plan	To meet objectives of the RISC specification	To be agreed within RISC project plan,	
Teams will participate in the pilot development of telehealth	To be agreed within the Dorset-wide telehealth project	To meet objectives of the telehealth project specification	To be agreed within the Dorset-wide telehealth project	
To achieve integrated Health and Social care locality teams		To agree a set of planned outcomes that are stages towards the achievement of integrated teams	To be agreed by the end of Q1	
Single line management for the service with social care	As agreed within TCS project plan	To meet objectives of the service specification	As agreed within TCS project plan	Monthly
In the BP business case for LTC, the LTC survey indicator will be incorporated and BPCHS will undertake a sample survey of patients on the caseload by Q4 of 11/12. Guidelines at Section 1.6 will be the basis for the survey		<p>By 2013, all people living with a long term condition should be able to say:</p> <ul style="list-style-type: none"> <li>• I understand my condition and therefore can make good decisions about my care and how I live my life</li> <li>• I know what I can do to help myself and who else can help me</li> <li>• I am treated with dignity and respect</li> <li>• I can enjoy life</li> </ul> <p>All case managed patients will know how to manage their condition after 3 months in the case management programme</p> <p>Provider to demonstrate they are meeting best practice guidance for care planning for patients with a LTC</p>		<p>By 4<sup>th</sup> quarters. This should have been reported on at Q4 11-12.</p> <p>Request that this is reported at end Q2 and Q4</p>

Report number of oxygen assessments undertaken.  The commissioners commit to reviewing roles and responsibilities and pathway for prescribing oxygen. Deferred to 2012-13 by commissioners.		The provider is able to demonstrate that they are meeting best practice for the monitoring of people on oxygen		By Q3 This should have been reported on at Q3 11-12. Request that we agree reporting at end Q1.
To participate in the development and introduction of a revised IAPT/Talking therapies pathway during 2012-13,		To met the objectives of the revised talking therapies pathway	As agreed within the project plan	

**8. Baseline Performance Targets – Quality, Performance & Productivity**

	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Frequency of Monitoring</i>
<i>Performance Indicator</i>				
3000 patients with a LTC who have a personalised care plan that meets the care planning commitment made in High Quality Care for all	-	3000	Score card	Monthly
Minimum of 1320 patients on the community matron caseload and have a personalised care plan		1320	Score card	
Number of hospital readmissions for those on community matron caseload, information gathering achieved through the support of commissioners	-	Baseline	Score card	Monthly To go in Section 5 part 4
Number of urgent referrals contacted within 4 hours		80%		
No. of non urgent referrals contacted within 24 hours and given an appointment time that meets their needs, when the patient is ready willing and able	-	90%	Score card	Monthly
Incidence of community-acquired grade two or higher pressure sore in older people treated in a community setting.	-	Baseline target to be agreed 11/12	Score card	Monthly
Provider to work towards full compliance with the eight regional hospital standards for patients with Dementia		Compliance by March 2013	Quarterly reporting on work in Progress to achieve compliance	Reports at end of 2 <sup>nd</sup> and 4 <sup>th</sup> quarter

