SCHEDULE 2 – THE SERVICES

A. **Service Specifications**

Service Specification No.	02/GMS/0069
Service	Planned Care Integrated Community Services NHS Dorset
Commissioner Lead	Clinical Commissioning Programme for General Medical and Surgical
Provider Lead	Norma Lee / Cara Southgate / Sally O'Donnell
Period	2014/15
Date of Review	To be Agreed

NHS Outcomes Framework Domains & Indicators

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

Key Service Outcomes

To ensure the provision of high quality, responsive delivery of integrated community services with effective use of resources to meet the needs of the Dorset population. It will build on evidence based best practice and support care closer to home. Care will be delivered by competent health and social care teams, with an appropriate skill mix, working seamlessly in the delivery of care and engaging with patients to promote self-management and self-care, offering maximum choice and control whilst effectively managing risk which optimises an individual's outcomes and wellbeing at every opportunity.

The planned care community service will be delivered by integrated teams of health and social care professionals.

Integrated services:
There is no one agreed definition or model of integrated care. The Royal College of General Practitioners (RCGP) preferred model for integrated care is 'primary care led, multi-professional teams, where each profession retains their professional autonomy but works across professional boundaries, ideally with pooled budgets and ideally with shared electronic record' (RCGP 2011).

The planned care community service will operate in the context of the Connecting Health and Social Care programme for Dorset which moves from alignment towards integration and supports the shift from hospital to locality and community based services.

1. Purpose

1.1 Aims and objectives
The aim of this service is to:

- Provide high quality integrated community services that improve the length and quality of life

by achieving a shift from a system based on treating illness to one focused on keeping people well and independent.
- Provide high quality nursing and therapeutic support to individuals in their own homes, including care homes and /or as close to home as possible
- Provide an equitable community service in each locality with a full range of services as part of agreed evidence based best practice pathways, to meet the needs of individuals with long term health and social care conditions, with non-urgent short term and/or complex conditions, and care at the end of life
- To offer choice and self-directed support
- Move toward integration of health and social care

The service will:

- Support people to remain at home for as long as possible, deliver safe and effective services with a significant shift in care from hospital care to care closer to home.
- Proactively identify and manage individuals with complex co morbidities and/or long term conditions who are vulnerable and at risk of unplanned hospital admission using the approved risk profiling tools as agreed with the commissioner
- Liaise with inpatients/bed based services and the intermediate care services to actively plan and support the timely discharge of patients from these services
- Work seamlessly across the interface of primary care, intermediate services, community services, mental health services and secondary care.
- Undertake multidisciplinary, person centred, single assessments in a timely manner that are sufficiently robust enough to inform Continuing Healthcare applications and Funded Nursing Care and Social Care needs assessments when required
- Deliver psychological support for patients and carers recovering from stroke alongside physical rehabilitation against the agreed psychological support pathway based on NICE Clinical guidelines 91: Depression in Adults with Chronic Physical Health Problems
- Staff will incorporate the use of psychological assessment tools including PHQ 9 and GAD 7 into mainstream assessment activity when assessing for signs of anxiety and depression referring on appropriately as defined within the pathway.
- Respond to the assessed needs of the individual and offer prompt, effective and appropriate person centred care; both scheduled and unscheduled in a timely manner
- Promote self-care and independence supporting individuals, families and carers to develop knowledge and skills they need to improve their health and manage health related conditions
- Support individuals to optimise outcomes and wellbeing with maximum choice, control and effectively managed risk
- Offer a carers assessment to all carers. If declined it will be re-offered at least annually if appropriate
- Engage in the development and the use of assistive technology such as telehealth/telemedicine/telecare
- Improve the quality of user experience across all services
- Improve efficiency and value for money

1.2 National/ local context and evidence base

In 2010 NHS Dorset published a four year Strategic Plan for a Healthier Dorset 2010-2014 and set out the key priorities for healthcare in Dorset, with a primary objective to help people to stay healthy, remain at home and/or return home following a bed based admission, providing care as close to home as possible.

As part of Dorset County Councils Transforming Adult Social Care the principle of early intervention suggests that supporting individual with modest needs, even those who are ineligible for services, may prevent the need for more expensive care later in life.

A number of key outcomes are identified for ‘transformed’ social care which link to Community Services, these are;

- Live independently
- Stay healthy/recover quickly from illness
- Have the best quality of life

Mental health and dementia care are a core component of service delivery and this is further supported in the recently published "No health without mental health: A cross government mental health outcomes strategy for people of all ages" (DH February 2011). The document sets out the government's ambition to mainstream mental health for people of all ages and sets down six key objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Commissioned integrated services will be supported by the Connecting Health and Social Care programme for Dorset which moves from alignment to integration and supports the shift from hospital to locality and community based services. This will require a shift in care and a fundamental change in the way both health and social care services are provided. This type of care delivery requires fully integrated response across health and social care, housing, employment, benefits and voluntary sectors as many patients along with their physical health needs will have social psychological, economic and environmental factors that cause additional complexities to their care needs.

Commissioning intentions have been informed by the following national guidance:

- National service framework (NSF) for older people 2001 / A New Ambition for Old Age 2006
- Our Vision for Primary and Community Care
- A Recipe for Care: Not a Single Ingredient
- Transforming Community Services: Enabling new patterns of provision
- Delivering Care Closer to Home: meeting the challenge (DH, 2008)
- High Quality Care for All: NHS next stage review final report (DH, 2008)
- NHS Next Stage Review: a vision for primary and community care (DH, 2008)
- Our Health, Our Care, Our Say: a new direction for community services (DH, 2006)
- National Quality Requirements in the Delivery of Out of Hours Services (DH, 2006)
- Taking Healthcare to the Patient (DH, 2005)
- NHS Operating Framework 2009/2010
- National Dementia Strategy (DH, 2009)
- "No health without mental health: A cross government mental health outcomes strategy for people of all ages" (DH February 2011).
- Your Health, Your Way – a guide to long term conditions and self-care
- NHS choices (2008)
- Intermediate Care – Halfway Home, Updated Guidance for the NHS and Local Authorities, July 2009
- Joint Strategic Needs Assessment 2010 – 2015
- End of Life Care Strategy (DH, 2008)
- NHS Improvement – Stroke Psychological Care 2011
- QIPP Long Term Conditions Workstream, Southwest Operational Phase 2011

Services must work seamlessly across the pathway of the reactive (intermediate services) and proactive (this service specification), planned, long term and short term community services.
The Enhanced Intermediate care service specification has been developed to meet the needs of people registered with NHS Dorset GPs who require intermediate care services when "care needs exceed those offered by 'routine' primary health care and social support, yet whose management

does not require admission to an acute hospital or to a long term institutional care setting".(Interim enhanced intermediate care services) The intermediate care service is expected to provide a reactive short term provision of rehabilitation/reablement and to undertake a robust assessment of an individual's need that informs any future health and/or social care interventions.

2. Service Scope

2.1 Service Description

Community services include a range of community based services designed to meet the needs of the local population at home or as near to home as possible. Integrated community services will provide mainstream support and management for people with long term conditions, complex co-morbidities, chronic disease management, disease prevention such as the delivery of vaccination programmes to those unable attend primary care services, short term/acute exacerbations, planned interventions, dementia and access to other specialist needs for example learning disabilities, end of life and older peoples mental health.

Integrated community teams may include community nurses; district nurses, community matrons, tracker nurses, community staff nurses, therapists, social workers, community care officers (CCOs) and generic support workers working with, mental health nurses, primary care, domiciliary care, voluntary and independent care sector providers and other partners in each locality. The teams will incorporate strong professional leadership.

Core services to be provided will include**:**

- Assessment of need that is person centred and incorporates the principle of single holistic assessment including physical, psychological and social needs.
- Care planning that is individualised, person centred and robust
- Psychological assessments when indicated, including the PHQ 9 and GAD 7 are completed.
- Psychological interventions will be undertaken at Step 1 and 2 with referral onto primary care mental health services (IAPT) for Step 3 or specialist mental health services for Step 4 when required (Please see IAPT pathway)
- Planned care and slow stream rehabilitation for people with long term conditions
- Proactive case management with identified key workers that link to the individuals GP
- Preventative health, self-care promoting independence; supporting advising and signposting patients and carers to relevant services both statutory, independent and voluntary for example centres for independent living
- Medicines management; review and management plan for each individual to ensure optimum therapeutic treatment plan and effective engagement of medicines management services/pharmacy
- Nurse prescribing in line with clinical competence, best practice pathways and patients group directives
- Effective prescribing practice for equipment in line with agreed protocols
- Tissue viability management and care/management of wounds both acute and chronic in line with best practice evidence based pathways
- Falls assessment and services to promote independence and reduce the likelihood of falls
- Nutritional assessments using evidence based practice/clinically approved tools such as MUST
- Promotion of continence and assessment of need for care and management including the arranging of the provision of continence supplies and referral to specialist continence services
- Catheterisation and catheter care this includes:
    - care of central venous access devices (flushing of lumens and care of the site)
    - Insertion and care of urethral and suprapubic catheters
    - provision of information and education to the patient/their carer regarding the catheter
- Phlebotomy, venepuncture for patients that are house bound
- Advanced nursing practice that maintains patients at home or as near to home as possible with an acute need/condition e.g. post chemotherapy, anti-emetic drug administration, parenteral

feeds and Intravenous therapies that may include;
  - Blood transfusions
  - Iron infusions
  - Zolendronate infusions
  - Antibiotics
- Palliative care and end of Life; general palliative care will be provide for all patient approaching the end of their lives to enable them to be cared for in the community, ensuring patient choice is promoted and facilitated, working in partnership with the patient, their family and all other relevant professionals to ensure a holistic approach including psychological assessment and needs being addressed.
- Safeguarding adults and children and make appropriate referrals adhering to national and local policy
- Continuing Health Care and Funded Nursing Care assessments and reviews in line with the National framework

NHS Funded Continuing Health Care (CHC) and Funded Nursing Care (FNC): Assessments will be undertaken in line with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH July 2009)

Outcomes:

- CHC check list to be undertaken for those individuals with on-going health needs, once they have completed a programme of rehabilitation and/or reached their optimum level of outcome and/or are to require on-going care i.e. domiciliary care package or placement in a care home with or without nursing. Checklist and if appropriate, decision support tool, must be completed prior to FNC determination being completed.
- Completion and submission to PCT of multidisciplinary/multi-professional person centred assessment, decision support tool and any relevant supporting evidence together with a clear recommendation as to whether the MDT consider the person is eligible for CHC to be completed for all individuals with a positive CHC checklist within the defined time frame as specified within the National framework
- Fast track applications for CHC to be completed for all individuals assessed as having a 'rapidly deteriorating condition that may be entering a terminal phase' using a fast track tool and presented to the CHC team with a care diary and a care plan within defined time frame as specified within the National framework
- CHC and FNC eligibility reviews to be undertaken at 3 months post decision, annually and/or at times of significant change or upon request from the CHC team.

Core services will be provided in all locations with the exception of patients registered with Lyme Regis Medical Centre, Cerne Abbas Surgery, Milton Abbas Surgery and Puddletown Surgery as these core services are commissioned through an alternative commissioning route .

Specialist practitioner services; The service will include the provision of specialist practitioners integrated into the multi-disciplinary, multi-agency teams that can provide specialist interventions when needed and who will maintain and lead the competency levels of those generic staff through training, support and guidance.

Outcomes:

- Patients will receive specialist interventions by an appropriate healthcare professional when required
- Care will be provided in an integrated way

Specialist practitioner services integrated into the multidisciplinary/multiagency service include (this list is not exhaustive):

- Falls and bone health assessment and intervention
- Continence services

- Anticoagulation services
- Heart failure nurse
- Parkinson's disease nurses
- Tissue viability services
- Pulmonary rehabilitation
- Adult safeguarding
- Adult and Older persons mental health services
- Dementia care nurse

Specialist services will be provided in all locations across Dorset.

This will include areas that DHUFT do not provide core services to as follows:
Lyme Regis Medical Centre, Cerne Abbas Surgery, Milton Abbas Surgery and Puddletown Surgery.

Transition from Children's services; The service will work with families and children when a child reaches their 14th birthday and is in transition from Children's Services to services traditionally thought of as adult services.
As part of the commissioning intentions this service will develop to include Children's Services to negate the need for any transitions to take place in the future. This will ensure that the provision of service is not disrupted, and patients are aware in advance of transition of the service that they will be receiving.

Outcomes:

- Person centred transition planning will commence on the child's 14th birthday
- Young people will receive a seamless service between children's and adult's services.

2.2 Any exclusion criteria

Patients registered with Lyme Regis Medical Centre, Cerne Abbas Surgery, Milton Abbas Surgery and Puddletown Surgery are excluded from receiving core services as detailed in this service specification but will receive specialist services as detailed in 2.1 above.

2.3 Geographic coverage/ boundaries

The service must be provided to all those individuals who are registered (Including temporary registration) with an NHS Dorset registered GP. Where the provision of the service to individuals who are not living within a locality boundary is required, additional arrangements must be made for the individual to receive the service which could include working with neighbouring community service teams.

The delivery of this service will ensure an equitable service operates to all those registered with a Dorset GP and that individuals are not disadvantaged because of their geographical location or because they are hard to reach. For example groups who suffer from social exclusion ,ethnic minority groups, including homeless people, travellers, asylum seekers, refugees, people with disabilities, those living in deprivation and prisoners. Members of these groups tend to suffer high levels of morbidity and premature death.

2.4 Whole System Relationships

Multi-disciplinary and multi-agency teams must work in an integrated care approach with a common purpose, learning and developing alongside each other, understanding and respecting each other's contributions and co-ordinating their services for the maximum benefit of individuals, carers, families and communities.

2.5 Interdependencies with other services

The following agencies directly and indirectly influence the work of community teams and therefore it is essential to ensure that systems are in place to provide good communication and a smooth transition for patients and carers between and across these services (this list is not exhaustive)

- Intermediate services
- Primary care teams
- Acute services
- Mental health services
- Health Visitors/School nurses
- Social services
- Carers
- Hospices
- Transition services
- Learning Disabilities
- Ambulance service
- Equipment services
- Community Pharmacies
- Voluntary sector/third sector
- Independent providers
- Offender health services
- Neighbouring local authorities and healthcare providers

A menu of support services that are funded under the reablement project board and may be accessed include:

Life style monitoring (Responsibility of Dorset County Council)

- Remote movement monitoring system which can be placed in an individual's home to allow people to be assessed in their own home and act as an aid to inform their long term assessment
- The placement of the units is only temporary but there is no time limit

Memory Advisory Service (Provided by third sector; Responsibility of Dorset County Council)

- Provides a local point of contact for people with memory impairment or dementia and their families at all stages of their journey, pre and post diagnosis.
- The memory advisory service will provide support and education for people with memory impairment or dementia, their families and care staff in localities
- The Memory Advisory Service will signpost individuals to further support services such as singing groups and Memory Cafes.

Memory cafes (Responsibility of Dorset county Council)– Will provide an accessible venue for people with memory impairment and their families to socialise, receive peer support, advice and guidance from Memory advisors and dementia specialists.

Singing groups (Responsibility of Dorset County Council) – Will provide a socially inclusive therapeutic session for people with a memory impairment or dementia and their families.

Where specialist services, are provided, they must enhance the work of the Community services/teams and avoid falling in to the trap of the specialist services becoming the focus, at the risk of distorting behaviour in a way that is not best for patients and leads to the neglect of general community service delivery.

2.7 Training/ education/ research activities

The service model will comply with best practice and it is the responsibility of the provider to ensure implementation of any best practice evidence based guidance. Services will be assessed against National Clinical Strategies, National Institute for Health & Clinical Excellence (NICE) Guidance, and agreed best practice. Where there is a resource implication a contract variation may be required. The Provider must be registered with and meet approved quality services in line with The Care Quality Commissions regulations and standards (2009)

The provider will be expected to comply with the clinical governance framework for NHS Dorset and

to function under agreed operational and clinical policies.
Clinical Obligations:

- If Statutory/Professional Registration is required it must be maintained at all times.
- The providers must ensure that each clinician takes responsibility for maintaining continuous professional development in order to meet requirements of professional registration
- All Clinicians must work within the boundaries of professional registration and relevant professional Code of Conduct.
- The provider must demonstrate that systems are in place to ensure that competencies are maintained and skills are up to date.
- The provider must ensure that sufficient numbers and grades of staff are employed in order to provide an appropriate skill mix and to ensure the service can be consistently delivered in accordance with the service specification.

- All staff will ensure compliance to statutory and legal frameworks implementing service developments in a timely manner as new directives are published

3. Service Delivery

3.1 Service model

The service model will ensure that community services are delivering the aims and objectives of this specification, that the services provided put the patient at the centre and that a holistic approach is taken to deliver the best outcomes for each individual.
The service model must be flexible to ensure that the service delivery can be developed working towards and achieving the commissioning intentions within the prescribed time frames.
The Provider will ensure it has a Business Continuity Plan in place so that all staff can respond to a Major Incident when required and that they will support other services and regional areas if required.

The service model will ensure that community services are aware of the distinct needs of different groups using their services, and that they address these needs to ensure equity of access and treatment for all.

3.2 Care pathways:

An integrated care pathway (ICP) is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical, psychological or social care experience to positive outcomes.
Within this specification pathways focused upon are:

- Preventative health and self-care,
- Anticipatory care
- Management/maintenance care
- End of life care

Care pathways will be further developed by multi-disciplinary/ multi-agency teams in each locality but must include:

Preventative Health, Self-care promoting independence; moving away from an illness orientation to one that looks to promote health and social care, assessing risk, preventing illness and understanding and addressing health inequalities. The promotion of the Recovery model will be implemented.

Psychological support : assessment of psychological needs using best practice approved pathways in tandem with the holistic assessment of each individual

Outcomes:

- Evidence based pathways for the delivery of psychological support by the community multi-agency workforce
- The use of approved assessment tools and techniques in the management and support of patients and carers following stroke and/or significant life changing events
- Appropriate referral to relevant services as defined with pathway

Anticipatory care; Person centred single assessment care plans that support individuals, families and carers to develop the knowledge and skills they need to improve their health and manage health related conditions

Outcomes:

- Proactive casework finding by the community services working in partnership with primary care using approved risk profiling management tools
- Delivery of disease prevention activity such as vaccination programmes
- People feel supported to manage their condition(as per NHS Outcome Framework)
- People have a person centred care plan that supports their individual, family and carers needs to include physical, psychological and social aspects of care
- People have anticipatory care plans which develop the knowledge and skills they need to improve their health and manage their condition.

Management of Long term conditions and short term interventions maintaining individuals in their homes/community: Proactive management of individuals including those with complex co morbidities and/or long term conditions who are at risk of repeated hospital admissions, with the ability to respond to the reactive, short term intervention such as the exacerbation of a condition.

Outcomes:

- Proactive management of individuals with complex co morbidities and/or long term conditions that includes the assessment, planning and evaluation of care that is individualised holistic and person centred
- In reach services to acute providers proactively identifying and planning early supported discharge from bed based services
- Delivery of the services that will maintain individuals wellbeing and optimise their outcome to remain at home for as long as possible
- Partnership working in a cooperative and collaborative manner with intermediate care services and relevant partner agencies
- IV therapies in the home or as near to home as possible
- Tissue viability and management of chronic wounds

End of life care. The service will be provided in line with the National End of Life Care Strategy and Quality Markers. This covers all individuals considered to have less than one year to live.

Outcomes:

- Proactive identification of people approaching the end of life, discussions and planning of care as the end of life approaches
- Increased numbers of individuals experiencing a ‘good death’ in their preferred place of care
- Seamless transitions of care as the needs of individuals are communicated across organisations
- Reduced numbers of inappropriate admissions and clinical interventions
- Increased numbers of individuals offered an advance care plan that encompasses preferences for care

3.4 Location(s) of service delivery

Services will be delivered in a variety of settings identified as being most appropriate to meet the individuals' need, while ensuring compliance with best practice care pathways.

3.5 Days/ hours of operation

- Core service delivery will be from 08.00 to 20.00 7 days a week 365 days a year from April 2012
- There will be a small number of occasions when a planned intervention will be required outside of these core hours and this will be provided by the enhanced intermediate care services

3.6 Referral Criteria and sources

Access route for all services to be through a clear referral pathway that is consistent and is available to a range of individuals and services and will be the referral route in for all community services.

Referrals will be accepted from hospitals, GPs, intermediate care services, community mental health teams, ambulance services, social care, self-referral, third sector, independent sector including care homes with and without nursing, and voluntary organisations.

3.7 Referral processes

Referral processes will be the responsibility of the provider and defined as the services are designed to meet the identified commissioning outcomes

Currently referrals are received in writing, by fax or phone

Minimum information requirement for referral:

- The provider should agree systems within each locality/general practice to receive referrals by face-to-face/fax/encrypted email and letter

- The referral/assessment should contain the following information:

    - Name, DOB and address
    - NHS Number and the GP practice details
    - Referral number (if given by single point of access)
    - Presenting Complaint
    - Reason for Referral – to provide expectation of service required by referrer
    - What has been provided so far? Psychology/counselling support, sick leave, medication, other agencies.
    - Effect on daily living e.g. employment, domestic problems or other effects
    - Current medication
    - Past medical and mental health history
    - Relevant background history
    - Coping methods? Drinking alcohol, avoiding work
    - Patient's expectations and aspirations.
    - Any risks to home visiting

The service which accepts the patient will liaise with the patient and the GP to ensure the patient is seen within target timescales and that the referring professional is aware that care has been initiated.

3.8 Discharge processes

The provider will ensure that as an individual is accepted on to a caseload or admitted into bed based services they will be provided with an estimated date of discharge. Patients will be discharged from care at the appropriate point on the care pathway.

3.9 Response times and prioritisation

Referrals must be assessed on the day they are received and triaged appropriately to determine the appropriate response and ensure the appropriate professional/service responds

Urgent: Respond immediately with a maximum of 2 hours to contact and assessment

Non urgent: contact within 24 hours to arrange an appointment which meets the individuals needs

4. Other

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Enabling services include:

Assistive Technology: To incorporate the use of assistive technology such as Telehealth and Telecare systems to enhance and improve the patient centred experience and give the patient more control over their condition.

Single Point of Access: Accessible 24 hours a day for a range of individuals and services that can provide information and appropriate access to the right care at the right time. The service will establish a point of contact for health and social care professionals, including care homes and the ambulance service into intermediate care, community assessment and rehabilitation, long term conditions management and palliative and end of life care; This will provide call handling and clinical triage of referrals to these community services to avoid unnecessary hospital admissions; It will work with other agencies and service providers to manage the interface between hospital and community-based services.