

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	04/GMS/0186 v2
<b>Service</b>	Integrated Nursing Service – Cerne Abbas
<b>Commissioner Lead</b>	Primary Care Team- Dorset CCG
<b>Provider Lead</b>	<i>Cerne Abbas Surgery</i>
<b>Period</b>	1 <sup>st</sup> April 2018 – 31 <sup>st</sup> March 2020
<b>Date of Review</b>	31 March 2018 (mid point review)

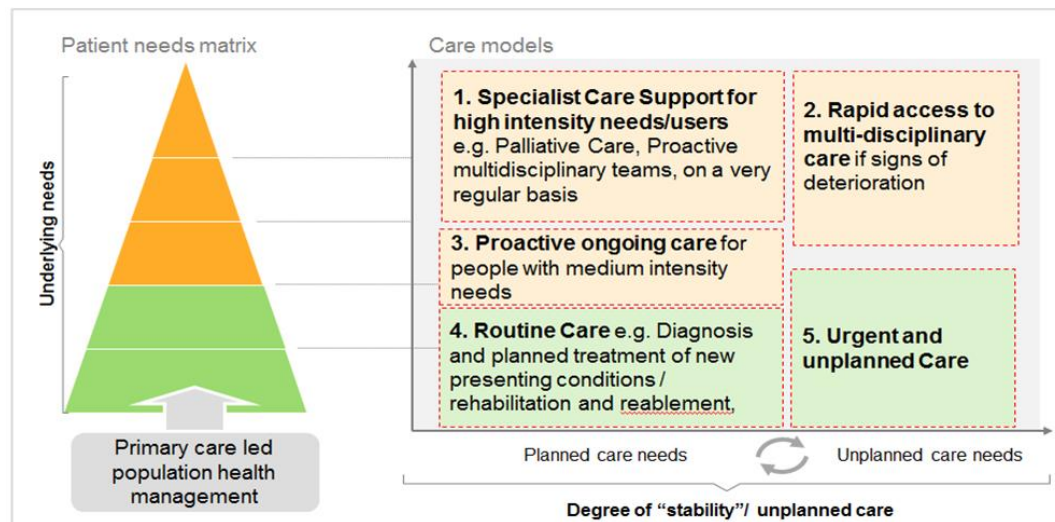
#### 1. Population Needs

##### 1.1 National/local context and evidence base

The case for change in community and primary care services is detailed in the Integrated Community and Primary Care Services (ICPCS) Outline Business Case. The specification of this service is designed to complement:

- Core GMS Services;
- Enhanced Frailty Service (Primary Care);
- Enhanced Integrated Community and Primary Care Services for High Intensity Users and Proactive Care for People with Medium Intensity Needs;

The Key Features and Functions of the Model of Care have been agreed by the System, the interdependencies between this specification and other specifications are detailed later.



It is expected that the providers of this service work with localities / networks:

- As part of the integrated workforce, with a strong focus on partnerships spanning primary, community, secondary, social care and mental health;
- With a focus on personalisation of care with improvements of population health outcomes and reduced utilisation of acute hospital bed resource.

Teams managing this group of patients will need to work effectively with local social services and voluntary agencies to ensure the necessary care packages are put in place for these patients. These teams will support the development of integrated service planning and delivery including health and social care team work, planned preventive care, admission avoidance, urgent care response, intermediate care and reablement.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
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	✓

### 2.2 Local defined outcomes

This contract contributes to the Core Outcomes for the Locality and the System as set out in the following specifications:

- Enhanced Integrated Community and Primary Care Services for High Intensity users and Proactive Care for People with Medium Intensity Needs
- Enhanced Frailty Service (Primary Care)

**The Specific Locality Outcomes:** Individual locality OBD targets are detailed within the [ICPS Dashboard](#)

## 3. Scope

### 3.1 Aims and objectives of service

To provide a high quality, responsive integrated nursing service, as part of the wider multi-disciplinary and social care team, to meet the needs of the Cerne Abbas Surgery population.

To compliment the delivery of the ICPCS model of care with a focus on the high impact change areas, specifically through the integration of nursing teams, to provide:

- Proactive management and rapid response to those most complex patients;
- Proactive management of people with long term conditions (LTC).

### 3.2 Service description/care pathway

The Integrated Nursing Team (INT) is designed to meet the core nursing needs of the local population at the surgery, at home or as near to home as possible. Integrated nursing 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 mental health.

The INT works in close conjunction with the wider Multidisciplinary Team which includes Health & Social Care Co-ordinators, Mental Health teams, Therapists, Social Workers and Generic Support Workers working with Primary care, domiciliary care, voluntary and independent care sector providers and other partners in each locality. The team will incorporate strong professional leadership.

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.

**Integrated Nursing Team Core services** to be provided by the Integrated Nursing Team at Cerne Abbas will include:

- All GMS general practice nursing
- 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
- Proactive case finding for 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
- Psychological screening and referral when indicated
- Care planning (including Anticipatory Care Planning) that is individualised, person centred and robust, with engagement of patients/service users and their carers in the formulation of personalised care plans
- Proactive case management
- 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
- Core community nursing service input into practice and locality multi-disciplinary team meetings

- Medicines management including review and management plan for each individual to ensure optimum therapeutic treatment plan and effective engagement of medicines management services/pharmacy
- Participating in the national Flu vaccination programme and other NHS immunisation programmes
- Nurse prescribing as appropriate in line with clinical competence, best practice pathways and patients group directives
- Effective prescribing practice for equipment in line with agreed protocols
- Support preventative health, self-care / 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 including:
  - information and advice about their condition and treatment options;
  - participation in the Expert Patient Programme;
  - participation in other structured education courses;
  - offer a carers assessment to all carers. If declined, it will be re-offered at least annually if appropriate.
  - health coaching;
  - peer support networks;
  - access to key workers/case managers;
  - supporting advising and signposting patients and carers to relevant services
  - assessment and management of individuals for the use of assistive technology (eg telehealth, telecare) 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
- Effective management of chronic wounds, such as leg ulcers, in line with best practice, including referral onto specialist teams as necessary; 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
- 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
- Identify patients for inclusion within the Gold Standards framework for end of life care.
- Palliative care and end of life care; general palliative care will be provided 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
- Phlebotomy 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
- Referral for advocacy for patients as appropriate
- Addressing the needs of carers to prevent carer breakdown
- 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 for NHS Continuing HealthCare.

**Specialist Practitioner Services:**

The INT will require access to specialist practitioner services that can provide specialist interventions when needed and who will maintain and lead the competency levels through training, support and guidance. This will ensure that patients will receive specialist interventions by an appropriate healthcare professional when required outside of the INT. This may include (this list is not exhaustive):

- Falls and bone health assessment and intervention
- Community Rehabilitation Team
- Continence services
- Memory Advisory Service
- Dementia Care Nurse
- Lifestyle monitoring / remote movement monitoring
- Heart Failure Nurse
- Pulmonary Rehabilitation
- Adult and Older Persons Mental Health Services
- Hospice services

**Days/Hours of operation:**

- The core service will be provided from 0830 – 1700, seven days a week, throughout the year, achieved through effective working with other community services such as intermediate care services.
- 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 services put in place by Dorset Healthcare University Foundation Trust.

### **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.

### **Referral processes**

Referrals can be received in person, writing/email, phone or as a Systmone task. The INT 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.

### **Response times and prioritisation**

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:**  
2 hours
- **Non-urgent:**  
Contact with the patient within 24 hours to arrange an appointment

### **3.3 Population Covered**

All patients registered with a GP at Cerne Abbas Surgery. Additional arrangements will be required for an individual that is registered with the practice but needs to be seen at an establishment outside of the practice area (defined in the practice contact) which may include working with neighbouring community service teams.

### **3.4 Any acceptance and exclusion criteria.**

#### **Acceptance:**

- Patients registered with a Cerne Abbas GP

### **3.5 Interdependence with other services/providers**

- Primary Care Frailty Teams
- Residential and Nursing Homes and Hospices
- Voluntary and Independent Sector
- Acute Care Services
- Pharmacy
- Ambulance Service
- Local Authority (eg Social Services, Housing, Children's Services)

- Learning Disability Services
- Community Mental Health Teams
- Intermediate Care Teams
- Equipment Services
- Carers Services
- Neighbouring local authorities and healthcare providers

This service has interdependencies with the following service specifications:

- ✓ GP Core Contract – there is a contractual requirement on the identification and management of patients with severe and moderate frailty.
- ✓ Enhanced Integrated Community and Primary Care Services for High Intensity users and Proactive Care for People with Medium Intensity Needs
- ✓ Enhanced Frailty Service (Primary Care) – 11J/0230
- ✓ Health & Social Care Co-ordinators - 01/GMS/0173
- ✓ Intermediate Care Service (Dorset) – 02/GMS/0023
- ✓ Community Beds –
- ✓ Diabetes Care – 11J/0217
- ✓ Chronic Obstructive Pulmonary Disease (COPD) Care Bundle – 02/GMS/53?

#### 4. Applicable Service Standards

##### 4.1 Applicable national standards (eg NICE)

The service will comply with best practice and it is the provider responsibility to ensure implementation of any best practice, evidence based guidance.

Fit for Frailty BGS 2014

Enhanced Health in Care Homes 2016 - <https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf>

Transition between inpatient hospital settings and community or care home settings with adults with social care needs <https://www.nice.org.uk/guidance/ng27> and Quality Standards 136.

##### 4.2 Applicable local standards

The ICPS dashboard will be utilised to monitor progress against expected outcomes with reporting to the ICPS Portfolio Board.

The Primary Care Home additional measures under development covering staff and patient satisfaction and staff workload will inform outcomes.

Quarterly: the locality will evaluate progress against expected outcomes and report to the East or West IHCS.

##### *Key Features and Functions of the Model of Care*

[https://nhsdorsetccg.sharepoint.com/:w:/r/sites/Transformers/PMO/ICS/\\_layouts/15/Doc.aspx?sourcedoc={77fe2e69-a9a1-422b-a10d-6cc11e6ceced}&action=edit&wdPid=628f6db6](https://nhsdorsetccg.sharepoint.com/:w:/r/sites/Transformers/PMO/ICS/_layouts/15/Doc.aspx?sourcedoc={77fe2e69-a9a1-422b-a10d-6cc11e6ceced}&action=edit&wdPid=628f6db6)

<b>5. Applicable quality requirements and CQUIN goals</b>
<b>5.1 Applicable quality requirements (See Schedule 4 Parts A-D)</b>
<b>5.2 Applicable CQUIN goals (See Schedule 4 Part E)</b>
<b>6. Location of Provider Premises</b>
<b>6.1</b> The Provider's Premises are located at: Cerne Abbas Surgery
<b>7. Individual Service User Placement</b>
N/A