SCHEDULE 2 – THE SERVICES

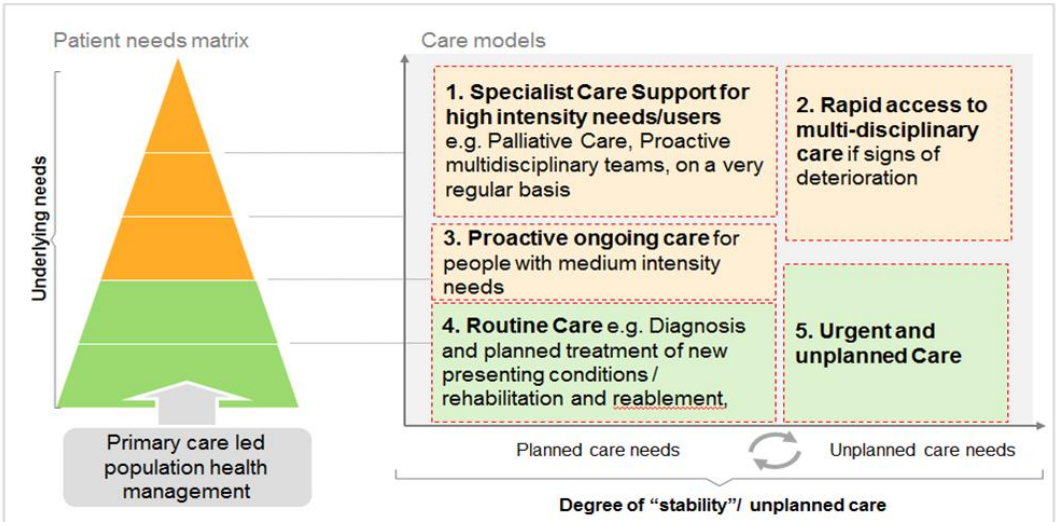
A. Service Specifications

Service Specification No.	11J/0244
Service	Community Services (Complex & Proactive Care, Lyme Regis and Charmouth)
Commissioner Lead	Dorset Clinical Commissioning Group
Provider Lead	TBC
Period	1 June 2019 – 31 March 2021
Date of Review	Annually

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. This service specification is designed to complement and contribute to the ICPCS Model of Care (defined below) by supporting our population who are high intensity users, as well as a proactive approach to 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 provider of this service work with the locality / primary care home 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.

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

The Specific Locality Outcomes targets are detailed Schedule 4 Part C Local Quality Requirements

3. Scope

3.1 Aims and objectives of service

The aim of the Community Services (Lyme Regis and Charmouth) is
to support the delivery of the integrated community and primary care model with a focus on the:

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

The services provided will include the following:

- **Integrated community services/Intermediate care – Core team to include:** community nursing, occupational therapy, physiotherapy, generic nursing/rehab assistants
  Service User

3.2 Service description/care pathway

The service will undertake acute assessment and diagnosis, crisis and rapid support, intensive rehabilitation/reablement and treatments for adults (in line with the 'Key Features, Functions and Outcomes' of the ICPCS Model of Care). The Service is an integral component of wider Integrated Locality Teams and will be delivered in partnership between Health and Social Care.

The service can be provided in a person's own home, in care homes (including where appropriate care homes commissioned to provide residential or nursing care step up/step down beds).

The service will build on evidence-based best practice and support care closer to home. Care will be delivered by competent health teams, with an appropriate skill mix, working seamlessly in the delivery of care and engaging with Service Users to promote self-management and self-care, offering maximum choice and control whilst effectively managing risk which optimises an individual's outcomes and well-being at every opportunity.

Core services to be provided will include:

- Active case finding and review mechanism for high risk Service Users;
- Support to primary care and locality multi-disciplinary team meetings.

- 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, with engagement of Service Users and their carers in the formulation of personalised care plans;
- Assessment, care planning and interventions (rehabilitation) for Service Users requiring admission for step-up/step-down care.
- Deliver community services, rehabilitation and reablement to all registered population in care homes (residential and nursing) or in their own homes.
- Proactive case management with identified key workers that link to the individuals GP;
- Comprehensive assessment to inform appropriate packages of care and rehabilitation for people with long term conditions;
- Medicines management including 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 Service Users group directives;
- Effective prescribing practice for equipment in line with agreed protocols;
- Effective management of chronic wounds, 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;
- Support initiation of home oxygen and review those on oxygen for more than 1 year, annually.
- 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;
- Catheterisation and catheter care;
- Phlebotomy, venepuncture for Service Users that are house bound;
- Advanced nursing practice that maintains Service Users at home or as near to home as possible;
- 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.
- Palliative care and end of life care;
- Provision or referral for advocacy for Service Users 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.

Days/Hours of operation:

The service will be provided from 0800 to 2000, seven days a week,

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:**
  Visit within 2 hours
- **Non-urgent:**
  Contact with Service User within 24 hours to undertake initial assessment with appointment made within a clinically appropriate timescale.

Discharge Criteria and Planning:

Discharge planning will begin when a person enters the service to ensure appropriate support is in place on discharge.
Teams will work with GPs and other health and social care staff as appropriate in planning discharges for Service Users with complex conditions to avoid duplication and omission.

Prevention, Self-Care and Service User and Carer Information:

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.

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 team will work to establish central information points to ensure consistent, accurate and up to date information is available to all Service Users and carers to support prevention, self-care and self-management.

The service will be provided from 0800 to 2000, seven days a week

3.3 Population Covered

All people over 18 registered with a GP in Lyme Regis or Charmouth

3.4 Any acceptance and exclusion criteria.

Acceptance:

- Service Users aged 18 or over registered with a Lyme Regis and Charmouth Practices
- Service Users transitioning from Children's Services

Exclusions:

- People under the age of 18 (except those transitioning from Children's Services).

3.5 Interdependence with other services/providers

- Primary Care Frailty Teams
- GP's and Primary Care Services
- Residential and Nursing Homes and Hospices
- Voluntary Sector
- Acute Care Services
- Pharmacy
- Ambulance Service
- Local Authority (eg Social Services, Housing, Children's Services)
- Community Mental Health Teams
- Intermediate Care Teams
- Equipment Services
- Carers Services

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This service has interdependencies with the following service specifications:

- Enhanced Frailty Specification 11J/0230E
- Health & Social Care Co-ordinators - 01/GMS/0173 inc Appendix
- Community Beds 11J/0245
- Primary Care Direct Access Musculoskeletal Outpatient Physiotherapy 04/MSKT/0002 v2

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

Fit for Frailty British Geriatric Society 2014

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

4.3 Applicable local standards

Refer to Schedule 4 Part C

Key Features and Functions of the Model of Care

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)

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6. Location of Provider Premises

The Provider's Premises are located at: TBA

7. Individual Service User Placement

Not applicable