SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**11J/0261**
Service	Ageing Well - Enhanced Health in Care Homes, Anticipatory Care, Urgent Community Response
Commissioner Lead	*PCC Directorate*
Provider Lead	*PCNs*
Period	*01 January 2022 to 31st March 2023*
Date of Review	*January 2023*

1. Population Needs

1.1 National/local context and evidence base

People in England can expect to live for far longer than ever before. But these extra years of life are not always spent in good health, with many people developing conditions that reduce their independence and quality of life. The long-term plan outlines what the NHS will do to support people to help them live as well as possible:

- Promote a multidisciplinary team approach where doctors, nurses and other allied health professionals work together in an integrated way to provide tailored support that helps people live well and independently at home for longer
- Give people more say about the care and support they receive, particularly towards the end of their lives
- Offer more support for people who look after family members, partners or friends because of their illness, frailty or disability
- Develop more rapid community response teams, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home
- Offer more NHS support in care homes including making sure there are strong links between care homes, local general practices and community services.

The National Ageing Well Programme has three component elements Urgent Community Response (UCR), Enhanced Health in Care Homes (EHCH) and Anticipatory Care (AC). The diagram below provides more detail of each element and the national and local aims for 2021 to 2023:

Ageing Well Programme Summary

To support the Long Term Plan objective to transform 'out-of-hospital care' and full integrate community-based care to support people with complex needs

Three Elements

Urgent Community Response

Crisis Response Care
- Within 2 hours from any referral routes
- By **March 2022** full geographical coverage required.
- Aim of single point of access
- **Services provided 8am-8pm, 7 days a week** as a minimum

Reablement Care
- Within 2 days from any referral source apart from hospital wards
- Interventions of than, but up to 6 weeks

Enhanced Health in Care Homes

2021/22 Priorities:
Foundation:
Clinical Leadership, MDT working, Digital enablement

National Continued for 20/21:
Deteriorating residents, Embedding framework

New National:
Falls, Dementia & Older Peoples Mental Health, Wound Care, Palliative and End of Life Care

Local:
Conveyancing, Personalisation and Care Planning

Anticipatory Care

Quarter 2 2021/22:
Anticipatory Care Operating Model to be published by NHS England and Improvement.

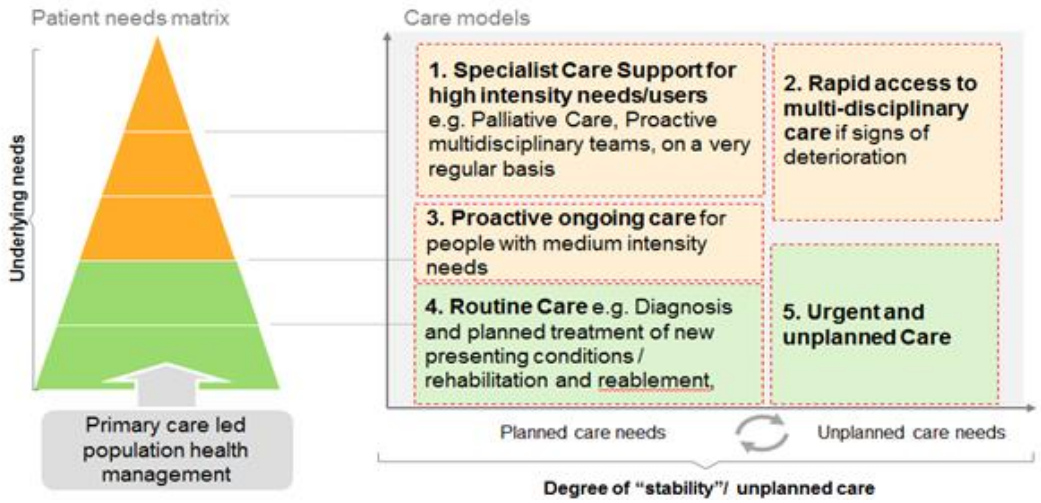
Quarter 4 2021/22:
Primary Care Network development of Anticipatory Care Models

From April 2022
Delivery of Anticipatory Care

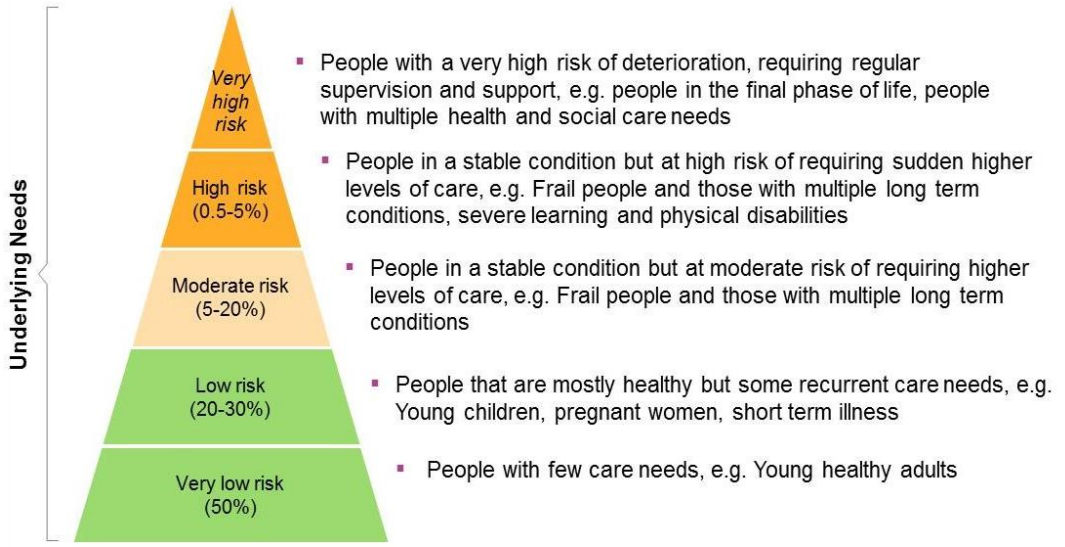
NEW Anticipatory Care Network DES to go live 1 October 2022

Local Context

Dorset is in a good position with regards to delivering on this key NHSE priority, with investment and progress already made to support those with Frailty, working proactively and in a coordinated way to support those in care homes and the development of aligned models of care implemented via our Integrated Community Primary Care Services (ICPCS) initiative.



This initiative proposed additional community-based resources that would enable people to manage their own health crisis through a variety of options. The community model developed is based on stratifying the local population needs. This then allows us to look to configure service delivery around individual levels of need in the most appropriate way. The five broad groupings of population need are outlined below.



The ICPCS initial level of investment (2018/19) primarily supported:

1. Enhanced integrated teams, with a focus on frailty.

2. LTC management for those identified with moderate risk and/or to provide increased pharmacy support to work with care homes.

3. Additional workforce (support workers) to support the reduction of stranded patients in the Purbeck Locality and the North Dorset localities.

Dorset, in line with other regions, consider the three elements of Ageing Well as one programme. The programme should therefore build on our existing teams and services. An element of Urgent Community Response will be delivered at scale across the Dorset population.
The Dorset vision for the Ageing Well Programme is to bolster and complement the services already in place that support our population.
The funding available to each PCN must provide additional capacity to meet the requirements of the Ageing Well Programme requirements. The intention is to link with stakeholders such as Community Services, Local Authorities, and the voluntary sector to plan and deliver a local service which dovetails into existing services, such as those funded through ICPCS, the Enhanced Frailty LES and funding to support the model of care for those in care homes (EHCH).
It is also recognised that in 2022/23 the Anticipatory Care and Personalised Care Directed Enhanced Service requirements are due to be released.

2.

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

Overarching

- Enable people to live healthy independent lives for as long as possible in their own homes, or the place they call home by reducing the need for escalation of care to non-home settings.
- Support people to die in their place of choice.
- Prevent unplanned hospital admissions for care home residents and fully utilising Personalised Care and Support Planning to ensure their care is proactive.

Urgent Community Response

- Provide an element of 2-hour response as described in line with B0651 Urgent Community Response 2-hour and 2-day, Standards Guidance.

Anticipatory Care

- Reduce variation of delivery of Anticipatory Care.

EHCH

- Further reduce inequalities for people living in care homes by ensuring all health and care needs are met through delivery of EHCH framework.

3. Scope

3.1 Aims and objectives of service

- Working collaboratively with relevant stakeholders (community services, Local Authority, VCSE etc), to develop a plan for delivery of the ageing well outcomes which meets the needs of your population.

- Provide interventions to enable people to live healthy independent lives for as long as possible in their own homes, or the place they call home.

3.2 Service description/care pathway

Overarching Ageing Well

- To ensure that appropriate Governance is established, to have oversight and joint decision making for the Ageing Well Programme and intrinsically linked services. Joint decision making must include changes to workforce and Staff movement to support other services.
- In partnership with stakeholders assess the workforce skill mix needed to deliver the Ageing Well Programme and identify skill gaps within your existing teams.
- Develop a workforce plan to meet the needs of the ageing well population
- Consider alternative additional capacity to deliver the programme, such as digital solutions, or use of / sub-contracting of voluntary services.

Urgent Community Response

- PCNs must collaborate with the at scale Urgent Community Response provider to ensure interconnectivity between services and agree a local approach to Urgent Community Response.
  Points to consider may include:
  - How referrals will be managed
  - Reporting of the 2-hour response standards to feed into the Community Services Data Set
  - Agree an average capacity for a 2-hour response.

Anticipatory Care

- PCNs to review and develop anticipatory care models in readiness for the release of the Anticipatory Care Network DES in October 2022, taking into consideration:
  - Population cohort identification: identify cohorts that are most at risk of unwarranted health outcomes.
  - Proactive care needs assessment: care planning for identified cohorts is conducted
  - Personalised care and support plans are in place and actively reviewed and managed, preferred county wide template for completion is the Dorset Care Plan.
  - MDT working and care co-ordination

Enhanced Health in Care Homes

- Develop and deliver a plan to support service improvement of the core components of EHCH.

Note:
PCNs may choose to subcontract any number of organisations to support this cohort of population. This could be:

- VCSE
- Local Authorities
- Community Service Providers etc.

PCNs will develop and submit a proposal for plan implementation, building on services already in place, to provide additional capacity and enhance collaborative working between stakeholders.

3.3 Population Covered

Adults living with frailty and with complex long-term conditions, living in Dorset and registered with a Dorset GP practice.

3.4 Any acceptance and exclusion criteria.

3.5 Interdependence with other services/providers

Interdependencies with the following services:
EHCH Network DES requirements
Enhanced Frailty LES requirements
ICPCS requirements

Interdependencies with the following providers:
Community services
Acute Trusts
SWAST
VCSE providers
Local Authority

4.

4.1 Applicable national standards (e.g., NICE)

Overview | Intermediate care including reablement | Guidance | NICE

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

B0651-urgent-community-response-2-hour-and-2-days-standards-guidance-may-2021.pdf (england.nhs.uk)

NHS England Report Template 7 - no photo on cover page 48: Enhanced Health in Care Homes

4.3 Applicable local standards

Funding allocations to be reviewed annually against submitted plans, any underspend against the plan to be recovered at financial year end 2022 / 2023.

5. Applicable Personalised Care Requirements

5.1 Applicable requirements, by reference to Schedule 2M where appropriate

- Adopt a Strengths-based (or asset-based) approach focusing on individuals' strengths (including personal strengths and social and community networks) and not on their deficits.
- Embed Strengths-based practice which is holistic and multidisciplinary and works with the individual to promote their wellbeing.
- Delivery will be outcomes led and not services led.