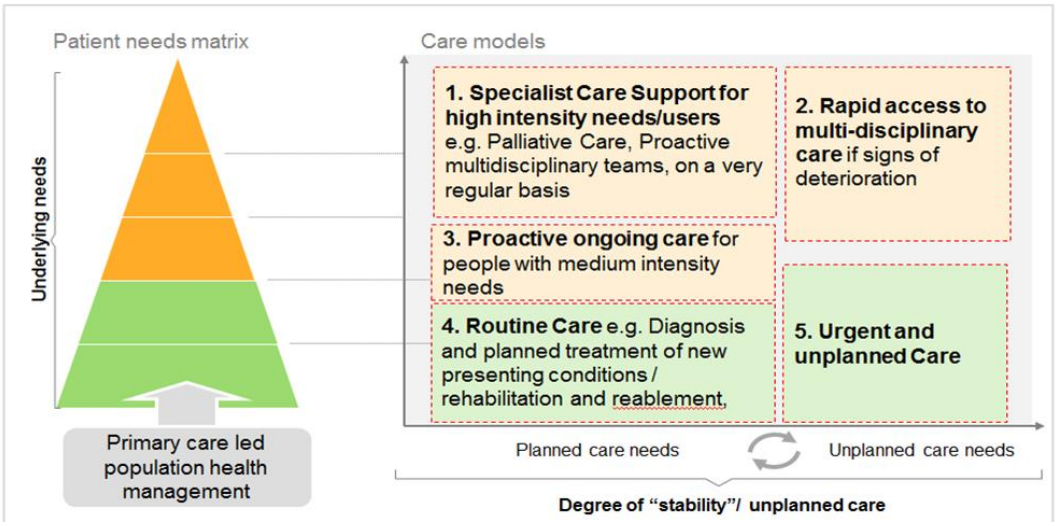
Enhanced Integrated Community and Primary Care Services for High Intensity Users and Proactive Care for People with Medium Intensity Needs

-Primary Care Providers/Federations

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 (ICPS) Outline Business Case. The specification of this service is designed to complement the services we already have 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 providers within a locality will come together to enhance established teams and further develop their approach with frail older people. Re-engineering of existing teams will support the productivity assumptions required of the ICPS model of care. Fundamental to the vision of this specification are:

- An integrated workforce, with strong focus on partnerships spanning primary, community, secondary and social care and mental health;
- A combined focus on personalisation of care with improvements in population health outcomes and reduced utilisation of acute hospital bed resource.

It is recognised that one size does not fit all, and localities will develop their enhanced services reflecting on:

- the current use of hospital beds;
- where community inpatient bed provision is going to reduce, and resources will be released to enhance the local workforce (Portland, Bridport, St Leonards & Wareham); and
- particular locality challenges.

Therefore, the services will be tailored reflecting on the key expected outcomes. Clear rational behind choices of service delivery must demonstrate collaborative working across providers to deliver the key features and functions of the ICPS model of care and the expected outcomes defined for each locality and our System overall.

The current workforce profile for the locality should have informed priorities and influenced the investment made in 2018/19 and will influence future investment within our integrated primary and community teams to support the implementation of the CSR. Providers will need to mutually agree with partners, through the Locality Governance process, any reductions in workforce due to turnover, and changes in the originally agreed baseline and additional workforce related to the new investment made in ICPCS in 2018/19.

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

Core Outcomes for Each Locality and the System:

Outcome Measure	Process of Assessment	Supporting Information
1. A Reduce occupied bed days in acute and community hospitals as measured in OBD per 1000 population over 65yrs = support CSR	ICPS Dashboard reporting to ICPS Portfolio Board on OBD's per 1000 population over 65yrs on rolling 12-month average – cluster comparison and locality	Practice level variance

reduction in acute bed days as over 65's account for a significant element of OBDs	comparison to ChenMed performance	
Contributing to the Outcome above		
1. B Reduce the number of people medically ready for discharge and awaiting discharge	ICPS Dashboard reporting to ICPS Portfolio Board on 12 month rolling data of No. of patients and total No. of bed days for people over 65yrs with LOS over 7 and 21 days	Daily Sitreps report
2. A Reduce admissions and readmissions for people over 65yrs = supports CCG Quality Premium achievement as over 65's account for significant element of admissions and this investment is targeted at this population	ICPS Dashboard reporting to ICPS Portfolio Board on over No. of 65's admission and readmissions on rolling 12-month average	Monthly update in Locality BI reports on the CCG intranet - emergency admissions Daily Sitreps report
Contributing to the Outcome above		
2. B Increase the number of people supported through outpatient or ambulatory care rather than with a hospital admission – most ACS admissions are for more than 1 day	ICPS Dashboard reporting to ICPS Portfolio Board on over 65yrs ACS admissions as a % of total admissions and the proportion with 1+ LOS	Monthly update to Locality BI reports on subset of emergency admissions % share of the ACS admissions for each locality compared to expected % share based on population
3.Enhanced community nursing and intermediate care workforce over 7 days a week	Reflect in locality proposals and impact following implementation of investment.	
4.Review and consider necessary changes to inhaled therapies dose or device to ensure the most appropriate clinical and cost-effective prescribing as per the Dorset formulary for people with asthma or COPD	Locality prescribing data will evidence savings achieved in respiratory care	

5.A locality workforce profile reflecting the baseline workforce for the ICPS model of care and how the investment closes the gap between baseline and the future workforce projections for the locality	Preference use the Wessex Practice Healthcheck Diagnostic Tool	

The Specific Locality Outcomes: Individual locality OBD targets are detailed within the ICPS Dashboard

3. Scope

3.1 Aims and objectives of service

To escalate the pace and scale of the delivery of the ICPS model of care the investment through this specification seeks to move localities towards the recommended ICPS workforce whilst focusing on high impact change areas:

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

3.2 Service description/care pathway

This specification focuses on the contribution of providers and General Practice working at scale, to provide services to population groups within the locality and enhance current provision of services to people with moderate and high levels of need. It is imperative that there is a focus on enhancing the skills and expertise to deliver the new model of care, and to reflect on how this contributes to the current locality workforce profile.

Each locality has developed proposals for implementation, building on core services already in place, reflecting on their current workforce profile and building and enhancing collaborative working at scale.

The investment associated with this specification is complementary to established services and is part of the 5-year plan to right size our primary and community workforce the pace of change will vary between localities. The interdependencies with core services and their specifications are detailed below.

3.3 Population Covered

The population living within the locality. This will require some providers to work with multiple localities.

3.5 Interdependences (Where applicable)

- Enhanced Frailty specification (primary care) 11J/0230
- Vulnerable Adults at risk of admission, Christchurch Locality 02/GMS/54
- Tracker Scheme for the Management of Vulnerable Adults at Risk of Admission, East Dorset Locality 02/GMS/56
- Integrated Nursing Service – Milton Abbas 02/GMS/188
- Integrated Nursing Service – Cerne Abbas 02/GMS/186
- Diabetes – 11J0217
- COPD – 02 GMS 0053

Current service providers in DHC, DCH, RBCH, Poole, Salisbury and Yeovil.
System working across all partners– in line with the East and West IHCS
Community pharmacy – the national investment in care home pharmacists will have an additional service specification linked to the additional national reporting requirements.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE guidance particularly for LTC, COPD, Diabetes and Asthma

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

Enhanced Health in Care Homes (NHS England)

Fit for Frailty (BGS)

- **Applicable local standards**

Monitoring:

- 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.
- Flu vaccination reporting
- PRIMIS reports for respiratory and diabetes

Key Features and Functions of Community Beds
https://nhsdorsetccg.sharepoint.com/:w:/r/sites/Transformers/PMO/ICS/_layouts/15/Doc.aspx?sourcedoc=%7B57E4999D-4DA6-4749-8593-CE3C9BD9EDC7%7D&file=Short%20Term%20Community%20Beds%20Key%20Features%20and%20Functions%20August%202017.doc&action=default&mobileredirect=true *and*
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