**Community Services Procurement**

**Adult Community Services**

**Key Requirements**

**November 2018**

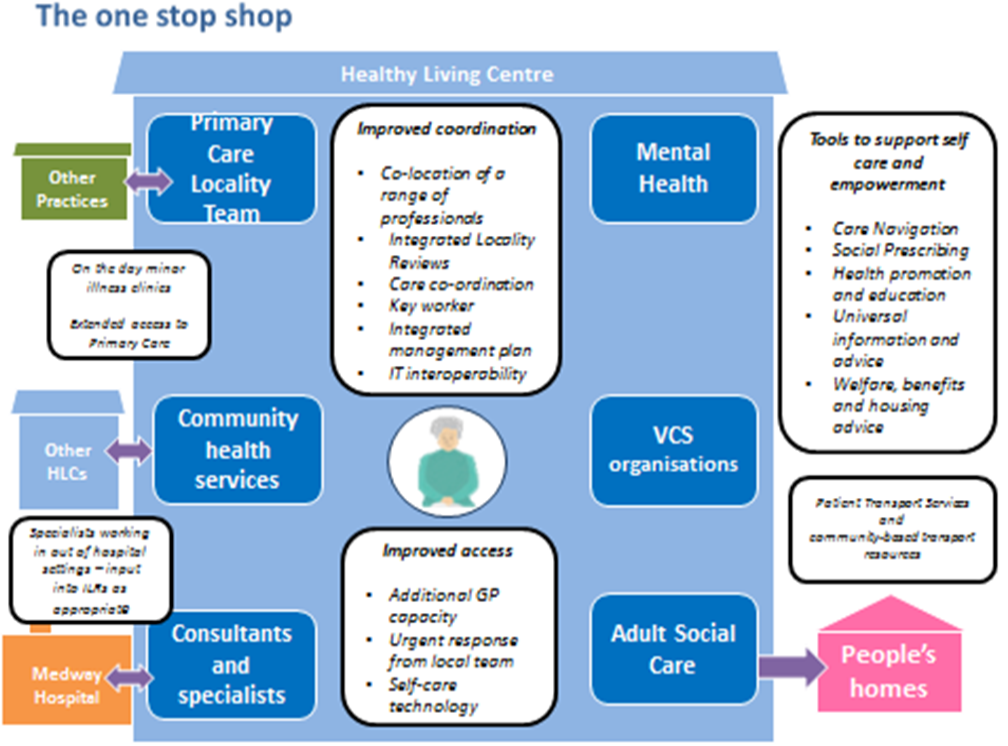
Draft

**Adult Community Services**

**1.0 Aims for Adult Community Services**

The overall aim of the adult community services model is to ensure the provision of accessible, high quality care that considers the holistic needs of patients and supports them to improve and maintain their health. Refer to Generic service specification for full aims.

The provider is expected to take a system-wide approach to delivering care locally, participating and working collaboratively with other organisations across the local health economy on both current and future care priorities. The provider will adhere to jointly agreed strategies, documentation and tools such as personalised care planning.



The revised model will see an improvement in collaboration between organisations, more flexibility within and between organisations to allow for constant improvements in services, and an improved use of intelligence on which to develop services.

**2.0 Key Requirements**

The Provider will:

* Configure **Community Locality Teams** (CLTs) to align with each of the six locality areas; Rochester, Strood, Chatham Central, Lordswood, Rainham and Gillingham, for Medway residents registered with a Medway GP.
* In addition, patients registered with a Swale GP, eligible and suitable will have access to the following services:

- Specialist palliative care, including hospice care

- Hand therapy

- CAS, MSK and triage

- Nutrition and dietetics

* Ensure each of the CLTs consist of an innovative mix of core and specialist clinical and therapeutic staff including (but not limited to):Nurses (including nursing associates, health care support workers and Advanced Nurse Practitioners. Community Therapies (including Physiotherapists (Physios), Occupational Therapists (OTs), Speech and Language Therapists (SALT) Podiatry and Dietetics.

The provider will ensure that this workforce will deliver the following key requirements across all care provision:

* Ensure that the core multi-skilled nurses and therapists have a **shared set of generic skills** and are able to treat and provide education for a range of long-term conditions including (but not limited to): diabetes, respiratory, urinary continence, wound and tissue viability and cardiology.
* Ensure that staff providing core functions are supported by **smaller teams of specialists** and are able to access responsive advice and support when required. The specialist function will also provide regular education and training sessions for the core staff, to help develop their competencies and enable them to manage patients with more complex conditions.
* The Provider will ensure that core and specialist functions will be provided either in clinic locations based in each of the existing **Healthy Living Centres (HLCs)** or if they meet the housebound criteria, in the home including care homes or any other type of supported living facility. Prior to the development of the 2 new HLCs the provider will continue to deliver services from existing clinic locations in the central Chatham and Strood areas. All staff will be located in CLTs.
* Ensure that clinical care for patients will be delivered by the most appropriately skilled professional within the CLT according to the patient’s clinical needs.
* Ensure that continuity of care is prioritised and the same staff are involved in a patient’s care on a regular basis. The number of separate visits from different staff should be minimised and the Provider will ensure that the multi-skilled workforce, provides a high level of seamless care that does **not operate in silos.**
* Ensure their workforce can deliver the following key requirements across all service provision:
  + For patients:
    - Support patients with single and multiple long term conditions, ensuring the right care and/or interventions are delivered at the right time. Patients will receive care from the most appropriate staff, reflecting complexity and specialist skills required
    - Have the right skills, knowledge and competencies to undertake holistic, evidence based assessment and care planning to determine and manage patient need.
    - Develop and contribute to integrated personalised care plans. Staff will ensure patients and their family or carers are actively involved in developing their care plan, including goal setting and agreeing treatment options. Plans should be regularly reviewed and updated, ensuring any changes are formally documented.
    - Provide patients with clear expectations about the service from triage to discharge. Clear exit arrangements will be in place to ensure that patients are discharged from the service when optimised.
    - Offer care that is holistic, focusing on self-care, prevention and empowerment; rather than just focusing on task orientated functions.
    - Use technology to maximise productivity, reduce duplication and minimise the possibility of delays in care.
    - Direct patients to the right support and advice to manage their own health i.e. care navigation; this can help patients to manage social isolation and any other issues that are impacting on their health.as well as work with services for on-going care and support if required.
    - Ensure staff offer advance care planning and end of life care and deliver improvements in the quality and frequency of advance care planning, to ensure that people approaching end of life or potentially within the last year of life are identified and effectively managed.
    - Listening to feedback from patients regarding their experience and care and ensure this feedback helps shape future provision.
  + Working with Professionals:
    - Work in partnership with professionals from external organisations for example social care, to ensure seamless, joined up working and to avoid duplication of provision.
    - Work closely with other professionals within the CLTs; seeking advice and guidance from the specialist support function for the most complex patients. Work closely with primary care to develop strong working relationships at an operational level through the alignment of named staff to practices or clusters of practices, to help facilitate joined up working within localities.
    - Contribute to and actively participate in Integrated Locality Review (ILR). Team meetings within each locality ensuring all concerns are appropriately escalated, discussed and any actions are followed up in a timely manner
    - Ensure systems and processes are in place to facilitate internal referral of patients if clinically appropriate, without the need to refer back to the patient’s GP.
    - Actively work in an integrated cohesive manner to ensure that community services and public health/health promotion services will promote conversations about prevention and healthy lifestyle behaviours at every point of care. The Provider will ensure this is aligned with the CLTs; staff will be able to provide advice and sign-post to the most appropriate services.
    - Integrate with the Community and Voluntary Sector (CVS) to ensure that patients receive support when required i.e. promoting well-being and helping patients to stay healthy for as long as possible.
    - Support the urgent response function as required.
    - Ensure there are contractual arrangements in place with secondary care providers in order to access consultant specialists to support patients with complex conditions (where appropriate). The Provider will work closely with secondary care to ensure continuous development and ongoing training; ensuring that staff apply the most up to date, clinically evidenced based practice when delivering care.
    - Staff should facilitate appropriate palliative care in conjunction with end of life services including working with the hospice and specialist EOL practitioners; this may include the development of advanced care plans and promotion of an electronic system to record patients’ wishes.
    - Provide any necessary equipment to support independence and activities of daily living in accordance with the Medway Integrated Equipment Services (MICES) contract. Liaison with social service and occupational therapists.
  + Working with Carers
    - Support, Advise and work with family members and carers
    - Staff are skilled at proactive and anticipatory care, supporting patients and their family/carers to recognise and manage changes in their condition.

2.1 Specialist Requirements

Specialist support is a fundamental element of the adult community services model.

Staff will provide:

* Expert clinical input and advice to each CLT
* Expert clinical input and advice to primary care
* Education, training and competency development to upskill community and primary care staff, this would include increasing the workforce that can prescribe from the non-medical formulary.
* Expert care targeted at patients requiring specialist intervention
* Advanced assessment, holistic care planning and co-ordination of complex patients

**3.0 Interventions**

Listed are a range of interventions that the Provider will be required to deliver in a joined up, holistic way that moves away from more traditional service models. This approach will mean the provider has to ensure that the nursing and therapeutic workforce are trained and have the right knowledge, skills and competencies to deliver a range of interventions taking a more innovative and flexible approach to care provision.

The provider should support patients to understand their condition and manage their treatment plan as outlined below:

* Cardiovascular conditions, such as Heart failure, Arrhythmias etc:
  + Liaise with specialist services where necessary i.e. anti-coagulation as well as public health services for lifestyle advice i.e. smoking cessation, weight management and exercise programmes.
  + Both nursing and therapy staff will work with patients to provide health education and advice, and rehabilitation to patients to improve quality of life and reduce the risk of further cardiac events and potential cerebrovascular events.
  + Undertake diagnostic testing (i.e ECGs, blood tests, 24 hour blood pressure, 5 day event recording) to assist confirmation of a number of cardiac conditions including (but not limited to): Arrhythmia, Heart Failure (LVSD) etc.
  + Undertake Phase 3 cardiac rehab community based structured exercise programs with patients in the local community or patient’s home with low to medium risk with mild to moderate co-pathologies.
  + Signpost patients to appropriate phase 4 programs cardiac rehabilitation programs.
  + Clinically assess the patients for signs and symptoms of a worsening condition and assess the effectiveness of anti-anginas and refer back for specialist opinion.
  + Diagnosis of the cause of patients heart failure
  + Assess for device therapy or other advanced treatments
  + Manage complex patients in conjunction with cardiologist.
  + Undertake the appropriate monitoring of the condition and blood chemistry following medication changes and will report adverse results to the GP
  + Agree advanced care planning as appropriate with the patient and implement as required.
  + Undertake diagnostic testing to ascertain and confirm the diagnosis of Arrhythmia
  + Improved identification of Arrhythmia patients by Specialist Arrhythmia Nurses visiting GP practices to improve targeted opportunistic screening
  + Provision of arrhythmia clinics, pathways and service
  + Support practices in reviewing their protocols for dealing with AF patients to ensure that approaches are evidenced based and consistent with current best practice
  + Support practices with timely and accurate results analysis from ECGs and where appropriate commence patients on treatment regime
* Respiratory:
  + Provide support for a range of respiratory conditions including (but not limited to): COPD, emphysema, cystic fibrosis. Support patients with pharmacological interventions (inhalers, pulmonary rehabilitation), and non-pharmacological interventions (smoking cessation advice) spirometry, home oxygen service, and inhaler technique training.
  + Improvement in quality of life (Measured using a Quality of Life indicator )
  + Reduce the levels of anxiety and depression in patients suffering from chronic respiratory disease through education, self-management and support
  + Patients demonstrating clinically significant improvement in function and maximised exercise capacity at end of pulmonary rehab programmes
  + Advice clinics offered where people with asthma can discuss their condition with a trained asthma nurse.
  + Spirometry assessment to monitor, maintain and evaluate patients in line with clinical guidelines.
  + Allergy assessment and testing to be run, according to demand, the following allergens are tested by skin prick testing:
    - house dust mite
    - grass
    - cat and dog
    - tree pollen
    - fungi
* Anti-coagulation
  + Ensure patients receive anticoagulation therapy and prompt monitoring
  + Improve anticoagulation control in patients, and reducing drug‐associated complications
  + Manage patients requiring testing and managing of warfarin levels through the use of venepuncture/or localised prick testing to obtain blood samples for International Normalisation Ratio (INR) monitoring.
  + Provide training and support for INR self-monitoring in line with NICE DG14 recommendations <https://www.nice.org.uk/guidance/dg14/chapter/1-Recommendations>
  + Take/receive results, interpret and advise on doses and liaise with patients.
* Phlebotomy
  + Undertake venepuncture and submission of samples to pathology services (where appropriate this may include sampling from difficult to bleed patients)
  + Undertake glucose tolerance testing where appropriate
* Nutrition and dietetics
  + Support a wide range of patients (including but not limited to): who require enteral tube feeding, or those with disease related malnutrition.
  + Management of gastrointestinal problems i.e. irritable bowel syndrome, irritable bowel disorder, diverticulitis, coeliac conditions, patients with specific diseases i.e. cancer, and those recovering from stroke or living with long-term neurological condition.
  + Manage patients (including but not limited to): with acquired disorders affecting communication and /or swallowing including progressive and non-progressive conditions, acute disorders, developmental conditions, disorders in voice production and fluency and those with cancer.
  + Optimising individual patient dietary needs by forming a treatment plan based on the medical and biochemical presentation
  + Ensuring Nutritional Assessment and Advice for patients with a range of complex chronic conditions is tailored to their specific condition and evidenced with best practice
  + Provide nutrition advice and expertise to support standard menu planning and delivery process.
  + Liaise and inform staff across agencies to make improvements to the patient meal time experience, generating supportive evidence when required.
  + Plan, develop, implement and evaluate training to clinical staff on nutrition and nutrition screening (including care staff in Medway outside of Trust – e.g. council and private nursing home staff).
* Mental Health conditions, such as dementia and cognitive impairment,
  + Offer psychological support and referral to talking therapies where clinically indicated.
  + Staff will have appropriate levels of mental health training and expertise to provide emotional and wellbeing support for patients with common mental health conditions, particularly those conditions that correlate with the presence of physical long-term conditions or disability e.g. anxiety and depression and those prevalent in older people such as dementia.
  + Provide dementia and depression screening and coordinate a service response from other health service professionals, the voluntary sector or specialist mental health services as required.
  + Meet the complex needs of patients including people who are cognitively impaired
  + Respond to patients with a dementia diagnosis who have a physical or behavioural change. They will provide short term support and work in partnership with ED liaison services to maintain patients independence and remain within their own environment
* Diabetes (including monitoring, advice, support and administering injectable therapies). The Provider should work collaboratively with GPs and specialist diabetic clinicians to:
  + Manage the administration of medication i.e. insulin and blood glucose monitoring and advice.
  + Support and work alongside the specialist clinicians to offer structured education for Type 1 and Type 2 Diabetic patients.
  + Provide structured education for Service Users with Type 2 diabetes
  + Provide structured education and care for Service Users with Type 1 diabetes
  + Provide a dedicated service to improve glycaemic control for Service Users with Type 2 diabetes whose glycaemic control is poor despite best efforts with self-management and in primary care
  + Provide pregnancy advice for women of childbearing age (QS7).
  + Provide specialist Type 1 diabetes care.
  + Provide a dedicated service to improve glycaemic control for Service Users with Type 2 diabetes.
* Continence
  + Undertaking assessments and physical examinations on patients with continence, bladder and bowel conditions including but not limited to: rectal examination (PR), urine testing, collection of stool specimens and review of bladder and bowel diaries.
  + Providing advice, and supporting the treatment and management of the following conditions (but not limited to): bladder training and re-training, pelvic floor muscle exercises, bowel dysfunction, constipation, faecal incontinence, encopresis, enuresis and nocturia.
  + Provide support with catheter management including (but not limited to): flushing, replacement, insertion, trial without catheter (TWOC), and on-going active management of urethral and supra-pubic catheters for both sexes. This also includes the by-passing of blocked catheters and practice and teaching with intermittent
  + Reduce the levels of anxiety and depression in patients suffering from bladder and/or bowel dysfunction
  + Provide skilled level three assessment, treatment and advice tailored to individual patient’s needs to achieve their goals and to maintain or regain continence or to manage bladder/bowel dysfunction where the problem is intractable.
  + Support comprehensive level two assessments carried out by core community services.
  + Provide continence products.
* Epilepsy:
  + Support a range of patients including (but not limited to): patients recently diagnosed with epilepsy, women with epilepsy who are pregnant, older people with complex co-morbidities etc. This will include prescribing, provision of advice and monitoring of anti-epileptic medications
  + Provide education will be on all aspects of living with epilepsy to individuals, families, formal and informal carers, and employers to patients on the active caseload.
  + Run an adhoc training programme within appointments on the use of buccal midazolam for individuals and their families and support workers from learning disability residential and care homes on active caseload.
  + Act as a key contact for individuals with epilepsy who are known to the epilepsy nursing service, registered with a GP as receiving drug treatment for epilepsy, and/or under the care of a consultant neurologist.
  + Support following diagnosis of complex epilepsy
* Adult Speech and Language Therapy Service
  + Assessment, diagnosis, therapeutic intervention and management of significant communication and/or swallowing disorders
* .Wound / Tissue Viability/ Lymphoedema
  + Management and care coordination of follow up care for patients presenting with cellulitis.
  + Provide (but not be limited to): routine postoperative wound care, complex and chronic wound maintenance, provision of wound management products such as pressure relieving equipment i.e. specialised beds and mattresses, and shared care with specialties such as plastic surgery, podiatry and dermatology.
  + Provision of dynamic mattresses for patients who meet assessed need.
  + Management and support of patients presenting with chronic oedema and lymphoedema.
  + Diagnose, treat and where applicable prevention of lower limb disorders. When appropriate it is expected that the core services will be able to perform assessment tests such as Doppler and measurement of ankle brachial pressure index (ABPI).
  + Reduce the complications of lymphoedema and chronic oedema such as cellulitis, secondary skin changes, disability and lymphorrhoea (leaking legs).
  + Ensure the provision of compression garments for people with lymphoedema, following agreed protocols for assessment monitoring.
  + Provide all bespoke items (made to measure items) and farrow wraps. GPs will be responsible for providing the off-the-shelf garments following recommendation by the service.
  + Support patient choice in the style and design of hosiery.
  + The service will follow best practice protocols for the rapid and effective treatment of cellulitis/erysipelas, including the prevention of recurrent episodes.
  + Support the identification of patients at risk of developing lymphoedema, regardless of cause.
  + Provide an organised education programme to health care professionals to raise awareness of lymphoedema.
  + Reduction in the incidence of chronic wounds by providing appropriate advanced wound bed preparation and wound management formulary leading to reduced admissions for surgical debridement and amputation.
  + Assessment and management of patients with complex and highly complex wounds and/or skin conditions.
  + Provision of specialist procedures such as sharp debridement, suturing, Topical Negative Pressure (VAC), Vascular Assist, PPG.
  + Vascular assessment for lower limb
  + Assessment, provision, administration and review of patients requiring dynamic pressure relief equipment.
  + Skin biopsy/minor skin surgery for patients with suspicious or chronic wounds.
  + Specialist technical treatments – VAC Therapy, Maggot Therapy, and Sharp Debridement, hydro surgical debridement – reducing the need for hospital admission for surgical debridement.
  + Shared care with plastic surgery, podiatry and dermatology – reducing unnecessary travel and outpatient appointments.
  + Provision of assessment and diagnosis of leg ulcer aetiology for ambulant patients
  + Provision of support for aftercare and prevention of reoccurrence of ulceration
  + Where wound healing is not an option, palliative care is provided with the aim of preventing infection, reducing trauma at dressing change and supporting the patient and family with issues such as dealing with pain, odour, haemorrhage and disfigurement.
  + Provide a community-based specialist foot care service which includes the triage of referrals to identify risk.
  + Diagnose, treat, and where applicable prevent and provide rehabilitation of lower limb disorders for adults (i.e. Doppler assessments and measurement of ankle brachial pressure index (ABPI), in line with the agreed access criteria.
  + Care management for diabetic patients who require non-complex podiatric care. Complex patients include diabetic patients who present with wound, ingrowing toe nails and ulceration. These patients should be referred to the Tier 3 Specialist Diabetes Service
  + Biomechanics
  + Manufacture and provision of prescribed foot orthotics
  + Management of ingrowing toe nails
  + Treatment of rheumatoid and arthritic and other age related deformities
  + Domiciliary nail care
  + Physical Intervention therapies (electro, laser, cryosurgery)
* Palliative Care
  + Work with GP to co-ordinate the inputs of specialist palliative care, local hospice and voluntary sector providers in accordance with clinical need.
  + Deliver end of life care in line with the effective principles of care for different stages of a patients care pathway as set out by Medway and Swale End of Life Programme.
  + Recognise patients in the “last year of life” or at the “end of life” and facilitate appropriate palliative care in conjunction with the end of life services i.e. hospice.
  + Support people at the end of their lives to die with dignity in the place of their choice.
  + Symptom control, when symptoms are proving difficult to manage at home and require more responsive approach.
  + Psychosocial support complex family/career dynamics that are impacting on the patents well being
  + Provide end of life care for patients with complex symptom or psychosocial and spiritual care issues which would be difficult to manage at home or other place of care.
  + Deliver end of life care in line with the effective principles of care for different stages of a patients care pathway as set out by Medway and Swale End of Life Strategy. Strategy documents available:
    - <http://www.medwayccg.nhs.uk/local-services/services-advice/end-of-life-care>
    - [https://www.swaleccg.nhs.uk/your-health/choosing-right-care/end-life-care/](https://www.swaleccg.nhs.uk/your-health/choosing-right-care/end-life-care/%20)
  + Recognise patients in the “last year of life” or at the “end of life “and facilitate appropriate palliative care in conjunction with the end of life services i.e. hospice. Support GPs in identifying those patients as suitable for these interventions and support GPs and clinicians locally to start the conversation.
  + Assessment of those patients who present in the terminal phase of their illness and offer to access appropriate interventions and “break bad news”.
  + Specialist level palliative care to be delivered across settings where people have need. This includes acute, hospice and community settings extending to marginalised groups such as the homeless, gypsy and traveller communities.
  + Staff should facilitate appropriate palliative care in conjunction with end of life services including working with the hospice and specialist EOL practitioners; this may include advance care planning and promotion of an electronic system to record patients’ wishes.
  + Offer advice and support to Healthcare professional in contact with the patient. One off assessment with patient and key healthcare professional. Patients known to the Specialist Palliative Care Service and new patients’ meeting the criteria for specialist palliative care may be admitted to the 15 bed hospice.
  + Ensure patients and their families have access to the latest up to date information booklets and important contacts and information. Using all documents and signposting in line with system wide agreed approaches, through the Medway and Swale EoL strategy
  + Work with the Hospice Wellbeing and therapy centre 6 week programme to help support patients/carers earlier to ensure there are informed and prepared;
    - Welfare Benefit advice/entitlement
    - Housing advice/advocacy
    - Maximising income through grant application
  + Staff should lead on/champion the development and ongoing maintenance of standardised tools, documents, processes for end of life/palliative care, including but not limited to:
    - Training and Education programmes
    - Advanced Care Plan document
    - Guidance booklets for patients and carers
    - Palliative care community medicines sheet
    - EPaCCS - electronic end of life register
    - Palliative care support line
  + Offer support to family and carers; anyone affected by the patient’s illness to be directly referred; either by the patient or another professional. Bereavement support to be available in the lead up to and after death. Support for carers and families to be from either under Specialist Palliative Care or the associated voluntary service, provided by Maidstone and Medway Cruse, to ensure all carers and families feel supported.
* Rehabilitation
  + Support patients who have previously suffered a stroke or who have a long-term neurological condition, but no longer require specialist intervention.
  + Provide therapy functions that offer comprehensive triage, assessment, diagnosis, treatment and rehabilitation for a wide range of conditions (including but not limited to): musculoskeletal conditions, hand therapy, neurological conditions, fallers, rheumatology, pain management etc.
  + Provide a needs led, patient centred and evidence based rehabilitation programme including musculoskeletal physiotherapy.
  + Support for patients to maintain their mobility and functional independence in terms of daily living skills
  + Identifying and signpost individuals who may be eligible for disabled funding grants to support building modifications in the home environment
  + Provision of equipment as part of the rehabilitation process
  + Falls risk assessments using the agreed tool, falls prevention activity and falls management programmes to reduce risk and increase confidence and independence
  + Neurological rehabilitation
  + Rehabilitation following fractures
  + Assess and treat injuries and conditions which affect the muscles, joints, and soft tissues, supported by self-management strategies and education regarding healthy lifestyle choices
  + Injuries which are treated by musculoskeletal physiotherapy include but not exclusively so, ligament sprains, muscle strains, arthritis, cartilage tears, pre and post-surgery rehabilitation, fracture rehabilitation, back pain
  + Active goal orientated rehabilitation and enablement in the community to maximise an individual’s functional ability and independence
  + Provide a range of services that promote active recovery from illness and maximise independence
  + Reduction in inappropriate referrals to acute services namely orthopaedic, rheumatology, and pain
  + Any patient where diagnosis, pathway or possible serious pathology is unclear or suspected form referral letter will be offered a face to face assessment with the most appropriate CAS clinician.
  + Spinal referrals represent one of the largest sub-specialities for referrals. Patients present with neck, thoracic or lumber, pain with possible neurological changes and possible referred pain.
  + The appropriate CAS practitioner will take clinical responsibility for the musculo-skeletal condition of the patient
  + Provide a comprehensive assessment of musculoskeletal, conditions for patients. The Practitioners use evidence-based and best practice to provide diagnosis and provision of diagnostics, complex treatments or referral onward to the relevant care pathway.
  + The practitioner will provide a comprehensive assessment of musculoskeletal, conditions for patients.
  + Complex treatments include provision of injection therapy, off the shelf or bespoke splinting or orthotics, complex / advanced rehabilitation, prescription or advice on medication
  + Lower Limb conditions covers hips, knees and feet.
  + Complex treatments including provision of injection therapy of the shelf or bespoke splinting or orthotics, complex / advanced rehabilitation, prescription or advice on medication
  + The referring clinician and/or GP will be kept informed of the patients assessment outcome, medication changes and planned onward care by written updates or direct contact or fax where more urgent intervention is required
  + The service will act as a source of specialist knowledge for musculo-skeletal conditions for services in primary and secondary care including providing education to local health care professionals
  + Assessment and referral for Telecare
  + Facilitation into short term Residential and Nursing Care placement
  + Specialist assessment in Activities of Daily Living taking into account cognitive, sensory, perceptual, motor and social functioning.
  + Cognitive or perceptual assessments and management strategies.
  + Assessment for basic self-propelling wheelchair.
  + Assessment for specialist wheelchair or special seating for a wheelchair.
  + Improved posture or improved independence.
  + Manufacture of Dynamic splint e.g. for radial nerve palsy.
  + Maintenance of hand function while await nerve recovery.
  + Orthopaedic pre-surgical assessment.
  + Carry out access visits or pre-discharge home visit assessments when necessary as part of the discharge planning process.
  + Community Physiotherapy
  + Improve functional ability in people with mobility issues/frailty/neurological problems/long term conditions.
  + Management of pain and other physical dysfunction arising from mobility issues/frailty/ neurological impairment/ long term conditions.
  + To provide physiotherapy treatment which results in patients being able to maximise their function within their home, reducing reliance on social care packages and health care services.
  + The Provider will minimise harm in the event of a fall, and support reductions in hospital admissions and unnecessary early admissions to residential care.
  + Deliver a timely and high quality falls prevention service dedicated to preventing falls, investigating unexplained falls and minimising injury caused by a fall. Including patients having been discharged following a fractured neck of femur who feel unstable and who are at risk of another fall.
  + The Provider will provide care, equipment, therapy and advice for fallers. It will ensure that potential contributory factors are investigated, such as medication review, physical support including equipment, home environment assessments and stability assessments.
  + The Provider will provide training, advice and guidance to care homes across Medway to assist in the management of falls in homes and assist in the prevention and reduction of future falls.
* Neuro Physiotherapy
  + Provide accessible, safe and effective neuro physiotherapy for the adult population of Medway.
  + To provide advice and support on how to manage active flare ups of chronic neurological problems.

In addition to this, the Provider will be expected to:

* + Administer where clinically appropriate advise on medications (including non-medical prescribing) in order to optimise their health outcomes, supporting psychological and emotional needs, and identifying palliative care needs.
  + Provide dietary, fluids and skin care advice as well as lifestyle and healthy living advice.
  + Provide Pain and symptom management
  + Deliver care through case management and care co-ordination to optimise care outcomes
  + Support and navigate patients with learning disabilities, and their families/carers to help them to experience improved health and social outcomes. This may include making adjustments or adaptions to routine care provision in order to accommodate individual needs.
  + Signpost patients to GP and primary care services, in particular support to access annual health checks, NHS Health checks, screening and immunisation services, health improvement services such as sexual health services, medication review, assistance to better understand specific and general health information, advocacy to excise choice of service.
  + Coach and teach carers (paid and unpaid) to support ongoing enablement
  + IV antibiotics management in the community, Insertion and management of cannula, central lines, PICC and Hickman lines. Follow up treatment including the insertion of a cannula or replacement of a cannula for the continuation of IV therapies will be delivered in community clinics or at the patients place of residence.
  + Medicines Management – administration, advice and support in regard to medication (including intravenous therapy) disconnection of chemotherapy.
  + Clinic Services available for ambulatory patients.
  + The service will provide clinics and home visits (based on client’s needs)
  + The service will develop specific local protocols with other service providers as required
  + Supporting transition between children and adult services.
  + Patients are given written and verbal information/advice as to how to maintain optimum health and independence.
  + The Provider will make optimum use of technology enabled care services and proactively promote the use of this to increase independence, self-care and to provide early warning of a need for intervention.
  + Support, advice and liaison on related care needs e.g. maternity, learning disability and employment.
  + The service will support the establishment of support groups, specifically for patients in Medway. This will be used in the ongoing evaluation of the service. The provider will share feedback from the support group with commissioners and will act on feedback when clinically and financially appropriate to do so.
  + The service will measure service activity, key performance indicators, and patient satisfaction; and will carry regular quality audits to monitor and evidence the efficacy and impact of the service. The service will strive for continuous development, learning from best practice and benchmarking, and working with commissioners in ongoing service innovation and development.
  + GPs and medical consultants will be kept informed with the patients consent, of the patients progress with regular written updates by direct contact or fax where more urgent intervention is required.
  + To provide care that is in line with recognised national standards and guidelines, that is evidence based and cost effective.
  + Support discharge of patients admitted to the acute trust
  + Prevent emergency and unnecessary admissions to hospital

1. **Eligibility**

All patients, 18 years or over, registered with a NHS Medway GP will be eligible to access community adult services with the provision of transitional care for those aged 16-18.

For particular areas of care eligibility may vary;

* patients 2 years of age and over are eligible to be seen within phlebotomy service
* to be determined

The pathways for referral and access to these services must be clearly documented and articulated before service start date. In addition, patients registered with a Swale GP, eligible and suitable for the following services:

* Specialist palliative care, including hospice care
* Hand therapy
* CAS, MSK and triage
* Nutrition and dietetics

There may be cases where it is clinically appropriate for adult services to provide treatment to those under the age of 16 e.g. complex wound care and continence issues (see 4.2)

Unregistered patients living within a Medway post code area should also have equitable access to services and should be encouraged and facilitated to register with a GP.

Referrals for patients registered with a GP practice in another CCG should be directed to the equivalent commissioned service in that local area.

4.1. Acceptance and exclusion criteria and thresholds

All patients registered with a GP in Medway will have access to community services, care planning and coordination functions. Where, following assessment, it is thought a patient is clinically unsuitable to be managed by the community service described in this specification, this will be discussed with the referring clinician and the Provider to support and coordinate access to the right alternative service provision. Any discussion will be handled considering the urgency of the referral and possible impact on patient care as a result of the re-directing.

4.2 Transitional Care

This specification primarily details adult services to be provided to those over the age of 18, however, the provider will also be required to provide professional input to those between the age of 16 and 18 years old as part of a transitional care plan coordinated by local paediatric services and primary care professionals. In each case the Provider will liaise appropriately with secondary care and community children’s services to ensure coordinated care and a smooth transition between services where needed. This provision should be appraised on a case by case basis in conjunction with the referring GP and relevant paediatric services; the Provider should deliver care where it is safe and clinically appropriate for an adult service clinician to do so.

This transitional provision may include (but is not limited to):

* Joint clinics with children’s services professionals
* Advice and support to health care professionals within Children’s Services
* Provision of information regarding adult services during the course of the transition period
* Contact with the patient and their family in advance of transition to adult services to provide information, reassurance and ensure a properly planned transition from children’s services.
* Provision of key interventions and investigations where clinically appropriate

4.3 Housebound patients

The term ‘housebound’ means an adult who is unable to leave their place of residence without the support of an ambulance or where for particular reasons their healthcare needs are considered to be managed more effectively in their home environment as opposed to attending a GP surgery or other community facility.

Where patients have a temporary or permanent reason that prevents them from walking or leaving the house (this could be due to physical or psychological illness/or surgery) patients will need to be seen at home by an appropriate professional for the time that they are incapacitated. Once patients are well again or recovered from surgery, they will no longer be classed as housebound and will be expected to attend a clinic in the community if ongoing clinical care/treatment is required.

An individual will not be eligible for a home visit if they are able to leave their home environment on their own or with minimal assistance to visit public or social recreational services (including shopping).

**5.0 Response times**

The central co-ordination function will provide access for patients, members of the public and partner agencies to services, which will support the population to receive clinically appropriate care and support at home or as close to home as possible.

The central co-ordination function will signpost patients to services with the aim of preventing inappropriate hospital attendances and admissions.

Patients will be clinically reviewed and prioritised via a robust assessment of their clinical risk. Once assessed they will be seen in relation to their need and within the time limits specified in the table below:

|  |  |
| --- | --- |
| Priority | Receipt of referral to central co-ordination function |
| Urgent | Face to face assessment with a patient within the Community Locality Clinic or usual place of residence within 2 hours of referral.  Where clinically triaged, some patients may require a response sooner than 2 hours (e.g. end of life pain management).  Where clinically triaged, and agreed with the referrer, some patients may be able to be responded to longer that the 2 hours, but with a maximum response time for face to face assessment of 4 hours. |
| Significant | Within 48 hours |
| Routine | Within 7 days |

Exception reporting will be required for patients that are not seen within the allocated priority slots.

Reporting on response times will be monitored through the response time KPIs.

All approaches to response times should be maintained in line with National best practice.