**The core of an Integrated Community Team**

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| **Service** | **Integrated Community Team: Senior Case Managers, Case Managers, HSPCs, District Nursing and Night Nursing Services** |
| **Commissioner Lead** | **Henry Leak** |
| **Provider Lead** | **Basirat Sadiq** |
| **Period** | **1st April 2018 to 31st March 2019** |
| **Date of Review** | **Periodically by Alliance Programme Group 2018/19** |

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| **Service Specification** |
| 1. **Introduction**   Since being established the West London CCG has been developing and implementing an integrated care strategy, which seeks to rebalance system activity away from responding to crisis and towards planned care, self-care and the prevention of ill health.  Building on previous programmes, independent evaluation, rapid learning and following extensive co-design work between patients, health and social care professionals and the voluntary sector, the local system has co-produced an **Integrated Community Team (ICT)** model. The model is a GP led system focusing on care coordination, case management and multi-disciplinary working. The model is the next stage on our journey to bring together physical and mental health, social care and the voluntary sector to plan and deliver care that meets patients’ holistic needs.  The ICT model aims to deliver more consistent care for patients in a variety of settings depending on the needs of the patient. This includes care delivery in the community, in patient’s own homes, in the GP practice, and within two multi-functional Integrated Care Centres at St Charles and Violet Melchett.  Mobilising from April 2018, the ICT will absorb an increasing number of care functions as services and contracts mature, and move to a single management structure, outcome framework and whole population focus.  The ICT will be responsible for the delivery of a single set of outcomes, including:   * People live independently for longer and are not socially isolated * Reduced need for secondary care / crisis intervention * Interventions are cost-effective and of high quality * Staff retention and development improves * Health inequalities are reduced * Duplication is removed and opportunities to use resources better are identified * Diseases are well managed * People tell their story once   The ICT model is an evolving model and as such this service specification will continuously be reviewed by the commissioners, the service provider and other key partners.  **1.1 Guiding Principles**  The future model of care will be guided by the following principles:   * Doing things well, once. This means:   + - a single management function, facilitated by System Integrator roles in the north and south     - a joint multi-agency clinical governance framework (supported by a clinical decision-making tool)     - a single point of access for ICT services, covering both planned and unplanned community activity * Fully aligned to Primary Care Networks and delivered via local PCH delivery units and responsive to local population needs * Focusing on prevention and proactive care to maintain good health for longer and reducing the need for unplanned care * Tailoring care to the individual not the service * Involving formal and informal carers within the team and interact beyond boundaries * Sharing information and resources appropriately between services to avoid duplication and enhance the integration of triage, assessment and resource allocation * Making every contact count so that as much as possible is done by one team member in a single intervention, utilising all the skills within the ICT to deal with people’s needs before referring out * Driving integration through the establishment of a single Outcomes Framework, which will form part of a wider Alliance Agreement to create a ‘one system’ ethos   1. **The Model of Care**   The introduction of the evolving ICT model from 1st April 2018 will require providers to develop multi-disciplinary teams who provide tailored support to patients, their families and carers and provide them with the skills and tools needed to better manage their health and social care conditions. Patients are not dependent on these services but they are there when they need them.  Professionals and Services will increasingly integrate into the ICT model and operate under a single management team that will:   1. Enable integration and optimal use of resources within the team to ensure the appropriate professional is supporting patients based on their needs 2. Enable liaison with GP and MDT members to assess needs of patients and identify patients who could benefit from receiving support from the ICT, focusing on LAS frequent callers, hospital A&E attenders, patients in Extra Care, Care and Nursing Homes and patients with physical health problems complicated by one or more of the following: social care needs, mental health problems, drug or alcohol problems, multi-morbidity (3 or more LTCs) and signs of increasing frailty and risk. 3. Align processes and systems to provide a robust single assessment of Service User needs, ensuring information is consistently captured and recorded on SystmOne, while referring to and using information shared by other services (this change will be supported by a single Service Development Improvement Plan across all ICT providers). 4. Provide high quality, fully integrated safe and effective services which:    1. are community-based    2. meet varying Service User needs, including those unable to leave their home    3. only refer to other services when opportunities to address the problem within the team have been exhausted or when it’s clinically appropriate to refer earlier    4. use tasking to reduce unnecessary detail in communications 5. Support the training and development of multi-disciplinary teams and professionals, ensuring the workforce:    1. are appropriately registered and have the appropriate skill mix    2. appropriate supervision arrangements are in place for all staff groups    3. are trained to the required levels to safely deliver care    4. Ensuring workforce scheduling and a duty system that enables rapid response to emergencies and provides the right level of coverage at all times    5. **Single Management Function**   The Operational Managers will work as part of a single management team. The single management team will gradually expand to encompass all professionals who work in services that form part of the Integrated Community Team.  ICT Partner organisations will continue to be responsible for their service and staff terms and conditions, payroll and employee relations and welfare. The single management team will :   1. Enable Team working and better integration 2. Ensure optimal use of professional time and skills 3. Enable liaison with GPs to assess needs of patients 4. Provide high quality, fully integrated adult service which is community-based and that meets varying Service User needs 5. Identify patients who could benefit from receiving support from the Integrated Community Team, focusing on LAS frequent callers, hospital A&E attenders and high-risk patients including those in Extra Care, Care and Nursing Homes. 6. Develop and operate a duty system that enables rapid responses to emergencies 7. Avoid duplication of tasks 8. Ensure appropriate skills mix across the team 9. Ensure coverage across practices during leave periods 10. Ensure liaison between Acute Discharge Teams and Integrated Care Centre Teams 11. Provide support and training to the workforce to enable the safe delivery of care 12. Promote staff satisfaction and retention. 13. Participate in service improvement and co-design initiatives to help improve integrated services across West London CCG.     1. **Clinical Governance of the ICT**   The ICT follows and applies the clinical governance principles for the delivery of services. This includes the use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development; clinical audit and patient experience. Each of the partner organisations involved in the ICT will have their own governance processes which govern the clinical practice of each member of staff. However to ensure a coordinated approach to the ICT governance, each provider, or nominated individual, will be expected to attend and be part of the ICT Integrated Governance Committee (IGC). The IGC provides a clear framework across a complex multi-agency system to ensure the health, safety and quality of the services provided as part of the ICT and also provides a single point of feedback for governance related issues across the model. |
| 1. **Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **X** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **X** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **X** | | **Domain 4** | **Ensuring people have a positive experience of care** | **X** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **X** |   **2.2 Locally defined outcomes**  **The Single Outcomes Framework (SOF) will form an integral part of the Alliance Agreement 18/19, which can be found in Schedule 2G.**  **Please refer to Schedule 4C & Schedule 6A for the detail of the SOF & Reporting Requirements respectively.** |
| **3. Scope: Aims, Roles and Functions** |
| **3.1.1 Aims**  The long term aim is to provide holistic integrated care that meets the needs of patients with Long Term Conditions and complex needs in West London. GPs and practice staff will work together as part of the Integrated Community Team and other services to effectively assess, identify risk early and quickly put in place the care and support necessary to actively avoid further deterioration and facilitate fast recovery through providing proactive assessment, social prescribing, care planning and reactive care support where appropriate.  The aim of ICT service is:   1. Primary Care Led 2. Responsive to planned and unplanned needs 3. Covers the adult patient population registered to GP practices in West London CCG. 4. Provides a single point of contact for service users with complex needs 5. Intervenes early to minimise deterioration, maintain health, optimising symptom management in line with patient lifestyle and choices. 6. Integrates care for service users so they don’t have to navigate a complex system 7. Is compassionate, caring and treats people with dignity and respect 8. Promotes prevention, wellbeing and self-care.   **3.1.2 Key Roles in the ICT**  The key staff involved in delivering Integrated Community Team include:  **GENERAL PRACTITIONERS**  GPs will be expected to:   * Identify and stratify patients according to their needs. Practices are advocates for this new way of delivering care and work to ensure their patients benefit from the ICT. GP practices are responsible for identifying patients and referring patients into the service. Practices should have a lead GP for the ICT and all practice staff should have an understanding of what the ICT is and they should be promoting this service to patients. * GPs should take responsibility for disseminating information and informing patients about the ICT. Patient information leaflets and posters are available from the hubs. * GPs have overall clinical responsibility for all their patients. Their roles will be delivered across a number of locations; at their practice, patient’s home or normal place of residence and the Integrated Care Centre. GPs will be working as a team to provide longer appointments for complex patients and will work in a more holistic way in assessing people’s needs. All complex patients must receive at least 3 one hour sessions over the 12 month period. * It is expected that the focus for the less complex patients will be more about prevention, building community links, awareness and self-care and while most of the activity will be carried out by the SCM, CM and HSPC, the GP will be expected to review and sign off any care plans developed for this group and provide additional input as per the specific needs of each patient identified in the care plan. * Running dedicated care planning sessions in the practice as well as offering ad-hoc appointments at practice. * Identifying patients for and running care planning sessions at the Integrated care Centres (Hub). * Supporting SCM and CM with memory assessments as part of the new MAS specification. * Liaising with hub geriatrician to ensure most appropriate patients are seen/discussed with geriatrician - including face to face and “virtual” consultation * Working with ICT to plan the patient’s discharge and provide out of hospital care. * Working with the ICT to regularly review the caseload, stepping patients up and down as appropriate to ensure best use of resources. * Conducting joint home visits with the ICT when appropriate * Employing multiple approaches to engage with patients including conversations with clinicians and practice staff; letters; and advertisement on website and reception area. * GPs to be aware of ONS4 [Personal Well-being ONS4 measures – Evaluating wellbeing](https://measure-wellbeing.org/measures-bank/ons4/) and ensure all patients have a ONS4 score/level which is reviewed and updated every 6 months. * GPs to use simple goal setting with patients to encourage behavioural change * GPs to use third sector services, to socially prescribe to appropriate services in line with a patients ONS4 score/level and goal.   It is expected that a fully qualified GP rather than trainees will be used to run the sessions in the Integrated Care Centre.  **PRACTICE MANAGER AND ADMINISTRATORS**   * Ensuring that the referral process is followed correctly and that patient information is shared correctly with the ICT. * Employing multiple approaches to engage with patients including conversations with clinicians and practice staff; letters; and advertisement on website and reception area. * Inducting ICT staff into the practice, ensuring there is adequate office space where available and supporting them to integrate with the practice team. * Generating regular monthly and quarterly reports that provide accurate data on patients, to support prioritisation of care reviews and booking of extended sessions. * Owning the Integrated Care Centre Assurance Pack for the practice and making sure all their GPs using the ICC hubs are aware of the requirements specified in the pack. * Making sure that the CQC are notified about the practice using the ICC hubs in line with the Assurance Pack. * Where appropriate redirecting patients to the ICT when they call the surgery re single point of contact. * Practice responsibility for the Practice Support Plan and having regular (at least quarterly) meetings with the ICT practice support or programme team to review progress. * Attending ICT development sessions as appropriate.   **SENIOR CASE MANAGERS (SCM)**  SCM are experienced nurses who manage the different practice based MCMW teams including case manager and HSPCs. The responsibilities undertaken by a SCM can be divided into two areas; patient care and management and leadership. SCM also are expected build and maintain relationships with GPs, practice staff and external organisations e.g. ASC.  The SCM management and leadership responsibilities would include mentorship and supervision and also clinical leadership ensuring that all complex patients with an LTC are on an appropriate disease management pathway, accessing patient education classes if needed and that the disease pathways are streamlined and as close to primary care as possible.  They can also serve as an invaluable resource for ICT with their skill set and knowledge base complimenting that of other ICT staff.  Other key functions include:   * Working with GPs and partners to identify and stratify patients according to their needs. * Conducting initial screening and triage, as well as a range of pre-assessments (over the phone or in person) for complex patients and coordinating full assessments at the hub. Being available to patients as the main point of contact for health and wellbeing issues, and signposting to the most appropriate care setting. * Leading and driving weekly hub session and inputting into practice based MDTs. * Working with complex patients to develop meaningful care plans (including anticipatory care plans), consolidating care plans with other ICT members and agencies, updating on SystmOne and sharing with patients. Supporting CMs and HSPCs to develop high quality care plans. * Regularly reviewing of care plan including following significant events such as hospital discharge and new diagnosis; advocating on the patient’s behalf; administering ONS4 and supporting with self-care (often with support of HSPCs); reviewing anticipatory care plans; coordinating discharge. * Initiate and provide appropriate clinical interventions to improve quality of life, based on professional qualification and practice experience. When necessary, referring to appropriate clinical care provider, diagnostics, social or wellbeing interventions. * Carry out new assessments such as falls and memory assessments as part of new pathways developed to support integrated care in line with their training and level of competence   **CASE MANAGERS (CM)**  Case managers are experienced registered health and social care professionals who manage complex patients, provide holistic care and support the development of HSPCs. CMs also work with GPs to identify and risk stratify patients according to their needs.  Other functions include, but not limited to:   * Working with GPs and partners to identify and stratify patients according to their needs. * Conducting initial screening and pre-assessments (over the phone or through a home visit) for complex patients coordinating full assessments at the hub. Being available to patients as the main point of contact for health and wellbeing issues, and signposting to the most appropriate care setting. * Leading, facilitating and participating in weekly hub session and practice based MDTs. * Working with complex patients to develop meaningful care plans (including anticipatory care plans), consolidating care plans with other ICT members and agencies, updating on SystmOne and sharing with patients. Supporting CMs and HSPCs to develop high quality care plans. * Regularly reviewing of care plan including following significant events such as hospital discharge and new diagnosis; advocating on the patient’s behalf; administering ONS4 and supporting with self-care (often with support of HSPCs); reviewing anticipatory care plans; coordinating discharge. * Initiate and provide appropriate clinical interventions to improve quality of life, based on level of professional qualification and practice experience. When necessary, referring to appropriate clinical care provider, diagnostics, social or wellbeing interventions and following up on these referrals. * Carry out new assessments such as falls and memory assessments as part of new pathways developed to support integrated care in line with their training and level of competence.   **HEALTH AND SOCIAL PRESCRIBING COORDINATORS (HSPC)**  HSPCs are experts in care coordination, prevention, and supporting patients to access the third sector and other voluntary organisations. HSPCs play a key role in supporting SCMs and CMs with more complex patients, allowing them to enhance their skill set, while also being expected to manage less complex patients (tiers 0 and 1), and working with SCMs and CMs to support with caseload management.   * HSPCs can conduct initial screenings and pre-assessments (over the phone or through a home visit) for less complex patients, and can coordinate full assessments at the surgery or at the patient’s home. They will contribute towards coordinating MCMW Hubs and other appointments, including sending out appointment letters and organising transport if required. * If qualified and trained to do so, they can carry out blood tests, urinalysis and measure basic observations such as blood pressure, blood oxygen saturation, and temperature. They can also carry out assessments for equipment and minor adaptations. They will endeavour to meet all KPI targets set for them, for example around patient contacts. * HSPCs will participate in MCMW hub sessions, including contributing to the pre-Hub MDT involving the GP, pharmacist, and any other relevant health professionals. They will attend the monthly Frailty MDT, as well as the practice based MDTs for their assigned practice. * HSPCs will work with patients who are less complex to develop meaningful and personalised care plans, , with a particular focus on encouraging patients to adopt healthier behaviours, up skilling family and carers, and facilitating simple home adaptations. They will support patients to engage with third sector and voluntary services to reduce their social isolation and to access resources in the local community. They can support patients in navigating services such as People First, and other organisations promoting independent living and health. They can also support CMs with more complex cases where appropriate to do so. * The HSPC will review patient progress against goals set during the completion of the care plan, as well as agreeing on an anticipatory care plan to help the patient escalate any unforeseen health issues appropriately. They will complete the ONS4 template at appropriate intervals to assist in tracking the patient’s level of health and wellbeing, and escalate any issues identified as a result to the CM and GP. They will complete care plan reviews at the recommended intervals. They will advocate on the patient’s behalf where necessary and appropriate, and can contribute towards discharge coordination. . The HSPC will share care plans with other agencies and through SystmOne with consent from the patient. * The HSPC will initiate and provide appropriate clinical interventions to improve quality of life, based on level of professional qualification and practice experience. They will complete referrals where appropriate for both clinical and third sector services via the recommended channels, and will follow up on these where necessary. * HSPCs will carry out new assessments where appropriate, such as falls assessments as part of new pathways developed to support integrated care in line with their training and level of competence. * The HSPC will ensure good communication with their MCMW colleagues, including other HSPCs as well as CMs and SCMs, to ensure smooth provision of services. This includes prompt and timely communication of any absences via the appropriate channels, and ensuring their ledger on SystmOne is up to date and fully populated. * The HSPC will work in the MCMW hub providing dedicated support to GP’s and case managers in the running of the hub on the day. This includes undertaking recording of vital signs, phlebotomy and escorting patients to Xray and ECG clinics where required Providing hands on support to ensure patients have a positive experience of visiting the MCMW hub * The HSPC will support the health inequalities programme of work across the WL Integrated Neighbourhood Team. This will require them to be flexible and willing to work on specific projects per quarter to ensure targeted improvement in health & wellbeing outcomes for our patients * The HSPC will be an expert resource for social prescribing across the WL Integrated Neighbourhood Team, representing the service and leading on local social prescribing initiatives such as community corner in the Violet Melchett.   **DISTRICT NURSE TEAM LEADER**  District Nurse Team Leaders are experienced registered nurses with a specialist qualification in management and clinical leadership. Their role includes: case/work load management; End of life care and coordination; long term condition management; case management clinical supervision; clinical practice development; implementing quality standards; service improvement; GP link/liaison.  **DISTRICT NURSE DEPUTY TEAM LEADER**    Deputy Team Leaders are experienced clinical staff with all community nursing core competences. They assist Team leaders in managing a district nurse case load and team leadership in absence of a team leader.  They are also skilled in chronic disease management, end of life care, risk assessment and management, safe guarding,  mentorship of students and junior staff nurses, promotion of health and wellbeing, specialist link nurses e.g. Tissue Viability and continence management , Nurse led clinic for example Leg ulcer clinics .    **COMMUNITY STAFF NURSE**    Community staff nurses are registered nurses that perform most of the clinical competences such as Assessment and care planning, Tissue Viability wound management and pressure ulcer prevention and management. Leg ulcer management, Medication management, Anti-coagulation, Syringe drivers and IV therapy, Enteral tube feeding, continence management, catheterisation, bowel care, venepuncture, basic palliative care, basic chronic disease management and pre-reg. student mentorship    **HEALTH CARE ASSISTANT**    Health care assistants are trained at NVQ Level 3 or assistant practitioner level with a foundation degree in health and social care. They skills include; Sample collection, INR near patient testing, Catheter bag changing, performing of vital signs, venepuncture, simple wound care, pressure ulcer prevention, leg care and support hosiery and stoma care  The ICT, GPs and practice staff are ambassadors for the integrated way of delivering care, and work to ensure their patients benefit from it. This includes identifying patients who would benefit, delivering care and holding overall responsibility for the patients on their list. Improved diagnostic and disease management will be informed by an increasing understanding of the impact of multi-morbidity and indicators of increasing frailty on patient care processes. ONS4 will also be used to inform the delivery of services tailored to the patient’s level of activation.  **PRACTICE LIAISON STAFF**  As a key part of the interface with GP Practices, two Practice Liaison staff provides IT support and relationship building with Practices. They provide IT advice for the ICT, helping to build reports on SystmOne and creating Practice Support Plans that reflect the individual requirements of each Practice and sharing relevant performance data.  **INTEGRATED CARE CENTRE ADMINISTRATORS AND RECEPTION STAFF**  WLCCG has two ICC’s which are supported by an administrator and reception staff in each unit. The staff are required to coordinate the ICC appointments, support frail elderly patients and the wider ICT teams as well as ensuring the facilities at the two ICC’s are kept up to an appropriate standard under the management of the Hub Operations Manager  **3.1.3 Functions**  The Team’s activities have seven key function areas:   * Case Management * Nursing Tasks * Staff Management * Referral Management * Self-Care and Prevention * Supporting the running of the Integrated Care Centres and the wider ICT.   **3.2 Case Management**  **3.2.1 Disease Management**   * 1. Support **disease management** for complex Service Users, with effective **care planning.**   2. Organise and attend **MDT meetings**, i.e. regular joined up discussions between professionals, to discuss relevant patients.   3. Support the GP and members of local MDTs to provide high quality **planned and unplanned care** with the Service User at the centre of care provision.   4. Work closely within the Team to **support the reduction in service fragmentation** by owning patient care coordination and supporting effective resource allocation.   5. Provide a **seamless service which is fully integrated** with community specialist teams, operating as one service, from both a clinical and a Service User perspective. This means working jointly with other services, including end of life care, third sector and social care to provide a **package of care around the Service User.**   6. Undertake **Anticipatory Care Planning**, supporting patients to manage their conditions and assisting when they reach a crisis.   7. **Stepping down patients when appropriate** to enable the service to focus resources on patients with the highest acuity. Stepping down requires an asset based approach and a positive attitude towards risk.   8. **Respond to exacerbations and crises**, providing effective reactive support, working closely with CIS and LAS to avoid non-elective admissions, shadowing the CIS service to enhance the shared understanding of patients.   9. **Complete the appropriate parts of specialist assessments**, to support the process of diagnosis and referral to specialist teams if necessary. It is the ambition that the team undertakes this role for the majority of common issues encountered by older adults (e.g. Anxiety, Depression, Isolation, Diet, General Physical Rehab, COPD, Diabetes, Urological Disorders, Cardiac conditions esp. Ischaemic Heart Disease, Heart Failure and Atrial Fibrillation). For instance, to deliver appropriate **components of dementia assessments**, to support the Memory Assessment Service colleagues in diagnosing dementia and supporting patients who are newly diagnosed; to deliver appropriate **components of the falls multifactorial assessment**, as part of referrals to specialist Falls support.   10. Case Manage patients living in the community with complex needs, **including Extra Care Facilities, Care and Nursing Homes** and to support staff in these organisations.   11. **Monitoring patients in an integrated way through good communication with key partners** (e.g. GPs; LAS; CIS) and sharing information to help establish the patient’s condition without the need for a visit (e.g. remote monitoring using digital records).   12. **Helping Service Users and carers to understand and navigate the local health and care system themselves** providing assurance that when patients are stepped down, they are able to live independently without undue strain on their carer/s.   **3.2.2 Case Finding and Prioritisation**  Identifying the patients who would benefit most from an ICT intervention is done through a combination of:   * The WSIC dashboard * eFI (SystmOne) * Clinical judgment * Intelligence from LAS, CIS, Acute Trusts, Social Care records, practice staff and partners   When referring patients into the ICT, GPs can make a recommendation about which professional might be most suitable for the patient on SystmOne. The Manager of the service then makes a decision about resource allocation. Once patients are referred, the Team and GPs must work together to prioritise the patients who most need proactive care and support. Case finding should be continuous. Weekly as well as monthly MDT meetings in the practice are key moments to identify new patients to refer and to prioritise the case load.   * Initial case finding is led by the practice using the EFI and clinical knowledge of the patients. * Other professionals also have intelligence on patients that might benefit. * Practices should use other information and reports that can be created from the dashboard.   **3.2.3 Multi-Disciplinary Team Meetings/Working**  Monthly practice-based multidisciplinary team meetings are used to plan patient care and problem solve. These meetings are a part of mainstream primary care and should be owned by the practice, with the Team contributing actively. Attendance at MDTs is a vital part of integrated working. Resources and meeting times should be coordinated to enable the most appropriate staff members to attend practice-based MDTs.  Practices will hold a monthly MDT which should involve professionals listed below.   * GPs. * Senior Case Managers, Case Managers and HSPCs. * District Nurses. * Practice Nurses. * Social Worker. * Other professionals as needed, e.g. Primary Care Liaison Nurses, Hospice Teams, Geriatrician. * Community/Voluntary sector   In addition, the Team and GPs will usually hold shorter, daily or weekly MDT meetings.  **3.2.4 Preventing and Managing Crises**  Crisis prevention is a core aim of the ICT. It is about supporting patients, carers and their families to respond to exacerbations, deterioration and crisis in the most appropriate way by ensuring patients, carers and families:   * Are informed and enabled to act appropriately in case of an exacerbation * Have an up-to-date personalised anticipatory care plan (which could include a ‘Message in a Bottle’ and ‘Red Bag’ information). Where possible, this must include up-to-date patient observations and diagnostic metrics which enable professionals visiting the patient’s home (e.g. CIS; LAS) to understand what health metrics are ‘normal for the patient’. * Have a ‘What to do when you are unwell’ sheet   The Team take primary responsibility for proactive planning, but GPs also have an important role to play. The Team should work closely with Rapid Response when there is a crisis, providing additional capacity to respond to crises on a duty/rota basis.  Reviewing the need for and the content of a ‘What to do when you are unwell sheet’ should be a core part of the care planning process. It should be revisited after any unplanned hospital attendance and any time a change in patient baseline or condition warrants a review.  **3.2.5 On-going Management of Patients**  The case manager should ensure that long term conditions are managed in accordance with agreed guidelines (e.g. diabetics receive appropriate monitoring including Hba1c, eye screening etc.) and ensure the most appropriate person provides that care, whether it be the DN, GP, a Practice Nurse or if they have the relevant experience and qualification, that they themselves provide it.  However, once patients acquire 3 or 4 different diseases the treatments for one disease can interact with the treatments for another disease causing additional complications. Under these circumstances there is a need for an MDT review which optimises patients’ treatment in line with their individual and preferred lifestyle priorities. In other words with multi-morbidity patients will be unlikely ever to be symptom free so care plans should be designed to reduce as many symptoms as possible and to identify the symptoms patients are most able to tolerate in line with their preferred lifestyle choices. Therefore these patients need specialist multi-morbidity management rather than parallel single disease management which does not work for these patients.  **3.2.6 Transfers to and from Hospitals**  The Team works together and with the hospital discharge services (e.g. Home First) to ensure that patients can be discharged as soon as it is safe to do so, to avoid unnecessary stays in Hospital and Delayed Transfers of Care. Information needs to flow into the hospital from the ICT/Primary care to inform both hospital care and discharge options. These teams work together to reassure the Acute Trust teams and patients that appropriate support is available in the community, in the patient’s preferred place of residence. Innovative ways of working with the Acute Trusts will be a feature of the developing model of care.  **3.2.7 Supporting Enhanced Access, Social Care and Mental Health Practice**   * The Team will also undertake ‘Trusted Assessor’ assessments for minor adaptations and equipment. * Carry out Mental Capacity Assessments where appropriate in line with MCA Guidelines. * Use charity log to track referrals into self-care. * Organise transport for Service Users who are required to attend the Integrated Care Centres * The service should only provide services in the homes of patients who are housebound. In order to actively encourage independence and activity, non-home based clinical settings should always be considered first. * Staff will continue to be developed in order to provide a holistic service, creating multi-skilled generalists with specialist skills to support the wider ICT.   **3.3 Nursing Tasks**   * 1. Deliver treatment in the home or community setting, and where possible support the prevention of a hospital admission.   2. Prevent disease by working with specialist nurses, doctors and AHPs to implement disease protocols and guidelines and promote patient education, self-care and preventative health behaviours.   3. Promote rehabilitation, self-care and service user education.   4. Provide care which supports timely and on-going health needs.   5. Enable Service Users to remain well and independent in their own home.   6. Provide pro-active and personalised care, supporting the needs of the Service User, including when the Users are approaching end of life.   The nursing tasks also include the following:  **3.3.1 End of Life care:**  E.O.L. management and co-ordination:   * Support patients through effective case management to facilitate advanced care planning and transition to a deteriorating health trajectory. * Signpost patients and their families / carers to specialist psychological support and bereavement support. * Work closely with colleagues in palliative care services (Care Homes, hospices, third sector, etc.) to ensure people get appropriate and timely end of life care services proactively. * Provide end of life care coordination and attend relevant multi-disciplinary team palliative care meeting such as Gold Standard Framework. * Ensure the appropriate records / care plans are up to date and the relevant flags are ticked, this includes SystmOne and Coordinate My Care. * Be aware of End of Life Gold Standard Framework and best practice, seeking specialist advice when appropriate.   E.O.L. nursing :   * Provide nursing care for Service Users who enter end of life care, for those Service Users with a cancer and non-cancer diagnosis. * Provide pain and symptom management. * Respond promptly to changes in a Service User’s condition and ensure that the Service User receives timely care appropriate to their needs. Response time will be agreed with the referrer. * Pressure area management and continence care. * Access appropriate equipment for end of life care support.   **3.3.2 Wound Care**   * Assess surgical and non-surgical wounds. * Remove clips and sutures. * Change drainage systems. * Pack cavity wounds. * Plan, coordinate and provide care to the wounds until the Service User has healed or been discharged to the practice nurse or specialist service.   **3.3.3 Prescribing**   * Team to undertake supplementary prescribing to include medications and dressings. * Reduce waste and improve efficiency by complying with local wound care formulary. * All ICT members who have their independent prescribing status must ensure they follow the North West London prescribing guidance and formulary. * Liaise with ICC hub pharmacist/GP where appropriate.   **3.3.4 Central Venous Access**   * Administer Intravenous antibiotic therapy at home via PICC lines. * Flush dormant lumens and site care. * Take down chemotherapy pumps, which will support the prevention of hospital admissions. * Remove PICC lines for those Service Users who are end of life care and are in the active dying phase, either choosing to die at home or are unable to get to hospital. * Support Patient discharge from Acute settings with an on-going need for I.V. Therapy   **3.3.**5 **Chronic Disease Management support to practices**   * The service will be provided to long term, unstable Service Users with the following long-term conditions:  1. Diabetes 2. Chronic Obstructive Pulmonary Disease 3. Coronary Heart Disease 4. Ischemic Heart Disease 5. Dementia  * The care for these Service Users will be discussed at local MDTs and work closely with the allocated Case Manager so the Service User is at the centre of any care plan. * Work closely with social care and third sector partners to ensure Service User’s social needs are met. * Proactively plan and manage the care in partnership with GPs, to ensure that the most appropriate professional delivers care and that patients tell their story once.   **3.3.6 Continence**   * Assessment and management of the housebound population. * Management and treatment of the condition. * Prescribe containment equipment (pads, sheaths etc.). * The service to undertake 6 and 12 month reviews, via telephone where appropriate. * Educate patients and carers in continence management and the prevention of pressure ulcers and ensuring patient and carer access to a case manager when required. * If not housebound then referring patients to a patient education group, self-help and/or self-care group.   **3.3.7 Catheter Care**   * Provide care for the housebound population for urethral and supra pubic catheters. * Service User education. * Change parts of the drainage system. * Educate Service Users and their carers to promote independence. * To provide complete catheter care for all known patients, including urgent responses between 2-24 hours. Urgent responses must be coordinated with other staff across the ICT to ensure that the correct intervention is made in a timely fashion to avoid inappropriate admissions.   **3.3.8 Diagnostics**   * Provide testing relating to the management of chronic long-term conditions, for the housebound population:  1. Blood glucose. 2. Blood pressure testing. 3. Urinalysis. 4. Doppler testing- *to be provided for the housebound Service Users that have tissue viability problems, (or clinics for non-housebound leg ulcers).* 5. Phlebotomy. 6. Liaise with any professionals who see a Service User, to establish the best way to administer diagnostics. 7. Undertake PEFR, Spirometry and ECG with appropriate clinical training and support.  * For housebound patients, the most up to date diagnostic results and patient observations should be made available (e.g. via the ‘Message in a Bottle’) to other health and care professionals that may be visiting the patient’s house, to enable them to assess what is ‘normal for the patient’.   **3.3.9 Community Equipment assessment and provision**   * Assess and provide equipment to support early discharge. * Equipment provided to support independence and promote wellness, as per training competency. * In line with Mediquip guidance, annual assessments to be provided for Service Users. * For specialist equipment, work with partner organisation such as CIS to ensure appropriate equipment is ordered to promote independence.   **3.3.10 Administration of Medication**   * Administer medication to the housebound population where clinical skill is required for the route of administration (e.g. injections, infusions, intravenous drugs, eye drops and enemas and where possible, to rationalise the administration of regular medication, such as once daily regimes or the use of automated dispensing, to ensure cost-effective health care). * Where required, provide treatment through specialised equipment. * Check for medication compliance by Service Users and provide assistance when compliance in poor. * Working with pharmacists to adjust medication administration to the functional and cognitive abilities of the patient   **3.3.11 Nursing Support in Extra Care facilities and Care Homes**   * All nursing services to equally be provided in Extra Care facilities and Care Homes in WLCCG. * Working with extra care facilities and care homes to understand what training needs home staff may have to support up skilling of staff and enhance staff experience and capability.   **3.3.12 Triage and Risk Assessing**  External referrals for Community Nursing support will go via the SPA. Referrals are triaged and appropriate responses given (see 3.10 for response times etc.).  Referrals for case management will be via the GP. Once practices have identified patients who would benefit from the ICT case management service and gained consent, patients should be referred using the electronic referral form on SystmOne. Where ever possible, any additional information or reasons for the referral should be stated e.g. Is the patient’s condition complicated by a drug and alcohol problem? Are they being referred because of high A&E attendance which might benefit from case management by an advanced practitioner? These referrals will be triaged by the ICT and allocated to an appropriate staff member.  Internal referrals will, following management discussion, be made via ‘tasking’ on SystmOne to the appropriate professional.  Going forward it will be expected that all external referrals for the ICT will go via a single point of access, once the existing access points have been aligned and simplified.  All ICT staff will be expected to risk assess patients regularly to identify risks and prevent deterioration, putting in place measures to mitigate risk, ensuring any such actions are clearly documented.  **3.4 Self Care and Prevention**  **3.4.1 Supporting Self Care and Prevention with Social Prescribing**  Self-care is a broad set of activities that aim to empower patients and families to manage their own health. Self-care is making simple changes and must be reflective of where the patient is at any given time – self-care can be as simple as getting dressed every morning, or taking a walk around the house, it does not necessarily mean a referral into a service if the patient is not ready.  The ICT have a set of tools they can use to support patients to self-care. They include motivational interviewing skills and health coaching to change behaviours and to build patients’ understanding and confidence.  This can be useful at any time in a patient’s care but mostly as part of the care planning or review process.   * The ICT will carry out social prescribing as part of the care planning and review process. * Kensington and Chelsea Social Council co-ordinate and work with the voluntary and community sector in the WLCCG area * Voluntary and community sector organisations provide activities and work with the ICT to problem solve issues * The ICT, GPs, receptionists and practice staff should be aware of social prescribing and be able to signpost. * Refer people to appropriate CVS organisations   **3.4.2 Patient Activation Measurements**  The ICT will use ONS4 assessments to identify the confidence and ability of patients to benefit from the variety of self-care provision. The Team will enable self-care using social prescribing, i.e. recommending and referring to community-based activities and support to patients. Social prescribing is for all patients, KCSC have been contracted to provide additional capacity in the voluntary and community sector.   * Undertake ONS4 assessments for all patients including regular reassessment of ONS4 at yearly review stage and use Charity Log to track referrals and support Service Users to complete sessions. * Be aware of and keep up to date with existing local self-care and preventative options/ offers * Actively publicise and support patients to access approved digital applications that have been proven to promote health and support self-care (e.g. My COPD app). * Roll out the use of ‘Message in a Bottle’ to support patients in blue light circumstances. * Actively use any newly developed pathways to support self-care (e.g. use of ONS4 and PHQ4 to identify those with mental health issues)   **3.5 Caseloads**  SCM’s, CM’s and HSPC’s should be pro-active in managing caseloads of around 60 Service Users per FTE at any one time. The ICT should follow the Standard Operating Procedures to ‘step’ people up and down for case management.  **3.6 Practice-based Staff and Co-location**   * Staff must ensure that they have a strong GP Practice focus being active, visible members of the wider primary care teams. * SCM, CM and HSPC will, where possible, be predominantly practice based and where this is not possible they will ensure **daily** contact with the practice, attending practice meetings as required and ensuring the practice is aware if they are on leave or on training etc. * Professionals within the ICT share office and clinical space, using the principles of hot-desking. * As the ICT develops, co-location will involve other professional and services.   **3.7 Population Covered**  For nursing services, the ICT is for Service Users age 18 years and over (or 16 plus but in transition from children’s services) between registered with a GP Practice of NHS West London CCG and in accordance with **‘Who Pays? Determining responsibility for payments to providers’ (NHS England, August 2013).**  For case management, the ICT is currently for Services Users aged 65 and over registered with a WLCCG GP with complex needs. As part of the WL CCG transformation programme it is anticipated the services specifications will be refined to include all adults with complex needs.  In exception, service users under 65 with complex needs who would benefit from case management may be eligible.  Also, where staffs are based in one of the North Kensington practices, all adult Service Users impacted by the Grenfell fire will also be eligible for case management and preventative support.  **3.8 Accessibility and Acceptability Criteria and Thresholds**  For Nursing Services, Service Users will be 18 years or older except for those in transition from children’s services  The Service operates 365 days of the year including weekends and bank holidays. The Service is supported Out of Hours by the evening and night services. The hours of the Service will be continuous.   1. Community Nursing Day Service - 0800 to 2000 hours 2. Out of Hours Nursing Night Service - 2000 to 0800 hours   Out of Hours, 2000 to 0800 hours contact will be via the Out of Hours Night Nursing Service.  Patients under the care of the ICT in West London CCG will be provided with district nursing services from the core ICT team. An Out of Hours specification will be drawn up for ICT patients ensuring data and information sharing to enable the principles of ICT to be implemented by the out of hours services. The ICT will implement patient and carer education and anticipatory care plans to reduce as far as possible the need for ICT patients to use Out of Hours services. As far as possible ICT patients will be cared for exclusively by the ICT team.  The contact details, including mobile telephone numbers, must be shared with all GP practices and updated as required.  **3.8.1 Any Exclusion Criteria and Thresholds**   1. Service Users who are under 18 but not in transition from Children’s Services 2. Service Users not entitled to NHS care   **3.8.2 Referral Criteria for Nursing Services**   1. A professional, high quality service will be provided, without discrimination of place or individual for people who are referred with a specific community nursing need, or meet one or more of the following criteria: Post-operative Service Users who are unable to travel, 2. Service Users who are undergoing treatment whose health condition would be compromised by having to travel, 3. Service Users over the age of 18 who require complex wound care treatment and are housebound.   The Team will take referrals for Service Users discharged from hospital in need of follow up care where routine DN support is required (e.g. dressings, LTC management).  **3.9 Referral Route**  The referral process will be uncomplicated and auditable with clear escalation routes advertised widely (e.g. using “Tasking” on SystmOne”).  All referrals will be subject to the single clinical governance framework (and clinical decision making protocols) agreed with and shared between all ICT services.  **3.10 Response Times, Detail and Prioritisation**  As a function of the single management function, all referrals to the service are triaged, prioritized, acted upon and noted on SystmOne, the response time being dependent on the information received and the prioritisation of the need.  Feedback is given to the referrer within 24 hours of referral.  **3.10.1 Unplanned Care: Urgent response required to be signposted to CIS**  Rapid Response is a service that responds to a variety of clinical conditions that are **likely to result in a hospital admission if not responded to within 2 hours** and includes conditions such as those listed below. This list is not exhaustive but illustrative of the service provision:   1. Short term minor illnesses causing reduced mobility or functional decline (e.g. respiratory infection), 2. Urinary tract infection 3. Exacerbations of COPD (where Service User is stable) 4. Diarrhea/Constipation/Vomiting 5. Heart Failure (known) 6. Acute confusion with an identifiable cause (dehydration or infection) manageable at home (CVA ruled out) 7. Interim support for Unstable Diabetes (where admission not required) 8. New falls to ensure Service User is stabilised before accessing specialist services (no fracture or acute cause).   ICT staff will be expected to work across many pathways, dependent on competency, in order to maximise the beneficial impact on patients.  **3.10.2 Unplanned Care: Response required between 2-24 hours.**  Referrals indicate actual risk of deterioration of Service User’s condition if nursing intervention is not provided.  For those Service Users who require an urgent response and it is considered unsafe or holistically inappropriate for them not to be seen until the following day the referrer and the district nurse team leader will discuss the needs of the Service User and agreement reached as to how quickly the Service User should be seen.   The team leader, as part of the triage function will then arrange for the Service User to be seen within the timescale agreed with the referrer.  Close coordination is required between local partners (e.g. CIS, LAS, ASC) to ensure that response times are timely and appropriate to patient need.  **3.10.3 Planned and Non-Urgent Care**  **Non-urgent care: telephone contact within 72 hours and visit within 7 days or earlier as clinically indicated.** Nursing needs are clearly identified indicating potential deterioration without nursing intervention/monitoring.  **Planned care: telephone contact within 72 hours and planned visit arranged within 4 weeks.** To undertake a specialist needs led assessment/health screening where advice/support will maximise the continued independence of Service User/Carer.  **3.11 Record Keeping**  There will be a system of record keeping which is integrated via SystmOne, to ensure all Service User contact is recorded in one place, with all care needs documented within one care plan and which is managed via local MDTs (to include general practice).  The outcomes of all contacts will be documented on SystmOne to enable all contacts to be audited, the exact mode to be agreed upon. The Team will work towards a standardized approach to highlighting management/care plans and anticipatory care plans for ease of access of all.  It is expected that the improved system will eliminate duplication and improve the level of face to face contact time with Service Users.  **3.12 KPI’s and the Single Outcomes Framework for the ICT**  DISTRICT NURSING  Response times as per specification  CASE MANAGEMENT  Percentage of patients with a ONS4 score/with a repeat ONS4 score  Percentage of patients referred to Self-Care/ Social Prescribing  Percentage of patients with an up to date Anticipatory Care Plan.  Percentage of GP Population in ICT by tier  Percentage of patients in Extra Care Sheltered, Nursing and Care Homes with an up to date Care Plan  Dashboard utilisation for patient identification and management  Attendance at practice and practice based MDTs  See Schedule 4c for the detail  The ICT will be working to meet the expectations of the Integrated Community Team Outcomes Framework.  **3.13 Interdependencies:**   * Community Independence Service * General Practice * Adult Social Care * Local Hospices * Imperial College NHS Foundation Trust * Chelsea and Westminster Hospital * Guys and St Thomas’ Hospital * University College Hospital * Community Mental Health Teams * Local Authority * Continuing Health Care * Private Hospitals * Specialist Hospitals within geographic location such as Royal Marsden * London Ambulance Service * MacMillan and Marie Curie * Royal Brompton * Community and voluntary sector organisations   It is acknowledged that a key success factor of effective service delivery will be robust and productive working relationships between health and social care colleagues both at provider and commissioner levels. |
| 1. **Applicable service standards** |
| **4.1 Applicable national standards (e.g. NICE)**   1. Transforming Community Services; Transformational Guidelines (DH 2011) 2. NHS Outcomes Framework 2015-2016 (DH 2015) 3. Long Term Conditions (DOH 2015) 4. Everyone Counts: Planning for Service Users 2014/15 to 2018/19 (NHS England 2014) 5. The Government’s Mandate to NHS England 2016/2017 (DH 2015) 6. NHS Five Year Forward View, (DH 2014) 7. Leading Change, Adding Value. A Framework for Nursing, Midwifery and Care Staff. (NHSE 2016) 8. Living Well with Dementia: A National Dementia Strategy DH (2009) 9. One chance to get it right, Improving people’s experience of care in the last few days and hours of life. Leadership Alliance for the Care of Dying People, 2014 10. NICE Stroke rehabilitation in adults (June 2013) 11. NICE Older people: independence and mental wellbeing (December 2015) 12. NICE Dementia: supporting people with dementia and their carers in health and social care (November 2006, updated September 2016) 13. NICE Pressure ulcers: prevention and management (April 2014) 14. NICE Care of dying adults in the last days of life (2015)   **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**  **4.3 Applicable local standards** |