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| **Service** | | | Adult Community Services |
| Specification Reference | | | Generic Service Specification (Part 1 of 3) |
| Period | | |  |
| Last Updated | | |  |
| **1.** | | **Introduction and Context** | |
| 1.1 | | Summary/ Introduction | |
| Adult community services are an important element of the health and social care system. They support and are supported by GPs and primary care, secondary health services (including urgent care), mental health, social care, and the voluntary and community sector (VCS). Adult community services are defined as those services that help people optimise and maintain their health either in their own home or other out-of-hospital settings. They provide a wide range of care, from phlebotomy, to supporting patients to manage long-term conditions, to treating those who are seriously ill with complex conditions.  This outline service specification sets out the high-level requirements of the Provider in relation to adult community services. It references generic principles that the Provider will follow across all parts of the service model, which are in line with national policy and best practice and details the links with the core and specialist functions, which are in separate service specifications. This specification puts the model in the context of national and local policy/ strategy, whilst also recognising some of the local wider determinants of health that will influence and impact future service uptake.  The adult community services model has been designed to reflect a simpler service configuration, one which is based on larger core teams with a shared set of skills that are supported by smaller specialist functions. This outline service specification therefore, sets out the overarching principles and service delivery mechanisms that will apply across all adult community services. It references the role adult community services will play in moving activity out of the hospital into the community and the close collaboration required across all partner organisations to deliver an integrated and seamless system–wide service that puts the patient and their carers at the centre of the care planning process.  Whilst not all services within this outline service specification are within the scope of this specification, the Provider will be required to liaise with these services to ensure the development of co-ordinated, holistic care pathways. A full list of services that are in scope are listed in Appendix 1.  This document should be read in conjunction with the core service specification (Part 2) and specialist service specification (Part 3). All three documents provide the context to the complete service model and the required service functions to be provided by the Provider. This document must be considered alongside the NHS Standard Contract which contains requirements laid out in General Conditions and Service Conditions. | | | |
| 1.2 | | Strategic Context - national and local policy | |
| The Provider will ensure that adult community services operate in line with national and local policy and strategy, including, but not limited those that follow:  National   * Next Steps on the NHS Five Year Forward View * The NHS Five Year Forward View (FYFV) * General Practice Forward View (GPFV) * Kent and Medway Sustainability and Transformation Plan (KMSTP) * Better Care Fund (BCF)   Local  • The Medway Model   * Medway Local Care Sustainability and Transformation Programme * Medway End of Life Strategy * Urgent Care Re-Procurement * Medway Health and Wellbeing Strategy * Medway Local Estates Strategy * Medway Digital Strategy * Medway Cares’ Strategy * Medway Health and Well-being Strategy * Kent and Medway Stroke Review * Medway Voluntary Community Sector Better Together Consortium * Care Navigation Re-procurement * Medway Integrated Community Equipment Service (MICES)   The Provider must ensure that adult community services work alongside and interface with the whole-system strategies listed above (but not confined to those listed). For the Provider, examples of this will include:   * Ensuring developments in the digital strategy are incorporated into the new service model, so they become a key enabler to providing more efficient services. By building in flexibility within the model, the Provider will harness the efficiencies brought by continual developments in this field. * Ensuring that the new model for adult community services compliment and align to the new model of care for urgent care services. * Inputting to and proactively supporting the delivery of the Medway End of Life strategy. * Ensuring staff are trained in prevention (e.g. Making Every Contact Count), able to have conversations with patients about how to make healthy lifestyle changes and able to signpost/refer them to further support (e.g. from health improvement services)     Additional information relating to the above national /local strategies can be found in the CCG’s *Case for Change and Revised Model for Community Services* document.  Further references to these strategies will also be mentioned throughout the document where relevant. | | | |
| 1.3 | | National and local trends | |
| The resident population of Medway is approximately 278,000 and is estimated to grow to approximately 330,000 by 2035. While Medway has a relatively young population, the number of older people is set to increase - those aged over 70 will rise by 20% in the next 5 years. Older people have a higher usage of health and care services compared to other age groups, particularly hospital admissions and use of community services.  Medway has a lower than average life expectancy for both males and females. For males, the average life expectancy is 78.4 compared with an England average of 79.5. For females, the average life expectancy is 82 years compared with an England average of 83.1. Healthy life expectancy is also below average. For males, the average healthy life expectancy is 61.8 compared with an average of 63.4. For females, the average healthy life expectancy is 59.7 years, compared with an England average of 64.1.  In Medway, 16.4% of adults (all ages) have a long term condition or disability that limits their day-to-day activities. Whilst this is lower than the England average (17.6%), it equates to over 40,000 people. In some parts of Medway this percentage increases to almost 40%. This is based on adults of all ages, with the prevalence of long term conditions increasing in older population groups, with many people also having more than one long term condition. There are approximately 12,000 people in Medway who have three or more long term conditions.  For a number of long term conditions, including diabetes, obesity, hypertension and depression, the proportion of the Medway population registered with their GP as having these conditions is higher than the England average. This may place more demand on services relating to these conditions than average.  People are living longer with long term conditions, males are living for around 16 years in poor health and females over 20 years in poor health (22.3 years). Over these periods people are more likely to use services that support them with their health. On average, a person with a long-term condition requires six times more health and social care support as a generally healthy person (from Kent Integrated Dataset (KID) (2015-16); Carnall Farrar Analysis, reported in KMSTP).  It is estimated that approximately 16% of people in Medway have a common mental health disorder – such as depression or anxiety. This is similar to the England average and equates to around 31,000 people in Medway. However, mental health problems disproportionately affect people living in the most deprived areas and often go hand-in-hand with physical health conditions.  Lifestyle behaviours such as smoking, alcohol consumption, physical inactivity, poor diet and being overweight cause poor health, worsening of disease, multiple illnesses and early death. These tend to be worse in the more deprived areas of Medway.  Further public health/demographic information can be found in the following documents:  Medway JSNA <http://www.medwayjsna.info/>  Medway Public Health Profiles <http://www.medwayjsna.info/jsna-appendices-other.html> | | | |
| **2.** | **Service Description** | | |
| 2.1 | Description (including summary of overarching aims) | | |
| 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.  2.1.1 Over-arching aims of the adult community services model are :  • To realign service functions in order to make better use of resources and increase capacity and resilience within the community  • To improve access to adult community services by ensuring services are provided in the right place and at the right time  • To have a highly skilled and appropriately trained workforce  • To improve co-ordination of care, to treat the person, not the condition  • To ensure a greater focus on prevention and patient empowerment  • To make better use of intelligence to constantly develop and improve service functions to ensure they are targeted according to demand  • To improve IT interoperability, communication and information flows between functions and across organisations   * To ensure service functions are responsive when patients are in crisis   2.1.2 Services aligned to the Medway Model  The Medway Model outlines how Medway will address the challenges of the FYFV, the GPFV and the KMSTP. It has been developed in collaboration with all health and social care organisations across Medway and reflects Medway’s interpretation of the KMSTP Local Care agenda.  The Medway Model is a new way of joining up local health and care services so that when someone is ill, there are many more people involved in their care than just the patient and their GP. It is based on the provision of out-of-hospital services wrapped around six geographically defined localities:  • Rainham  • Gillingham  • Chatham Central  • Lordswood  • Rochester  • Strood  The Medway Model has initially focused on primary care and, working to the aims of the GPFV, has brought together GP practices into six Primary Care Locality Teams (PCLTs). These PCLTs are responsible for the health of local populations of around 30,000 to 50,000 and are based in the six geographical localities (as listed above).  The PCLTs are primary care (GP led) teams that will lead and co-ordinate the Integrated Locality Reviews. They will work closely with the CLTs and wider health, social care and VCS organisations to ensure the most complex patients within each locality are effectively managed by ensuring Integrated Management Plans are developed and reviewed on a regular basis.  The Medway Model aims to provide care closer to home at this local population level. Within each of the six localities, there will be a designated Healthy Living Centre (HLC). These are the physical buildings where clinics and services provided by health, social care, mental health, voluntary and third sector organisations will be co-located. This will bring together a range of clinical services, wider health and social care expertise, and the voluntary and community sector to support joined up ways of working. Currently four HLCs are already established in Rainham, Gillingham, Rochester and Lordswood localities; another two are planned for the Strood and Central Chatham areas and will be operational by 2020-2021.  Both the Medway Model and Medway Council’s ‘Three Conversations Approach’ are fundamental to the future delivery of health and social care across Medway and recognise that patients have better outcomes if they are involved in decisions around the care they receive. The aim is to ensure that people with long term conditions have access to information and services to help them address high risk lifestyle changes and manage their medical conditions better through social prescribing, care navigation, self-care and self-management.  2.1.3 Adult community services and the Medway Model  Adult community services are a fundamental element of the Medway Model. The Provider will configure Community Locality Teams (CLTs) to align with each of the locality areas; these teams will serve their respective local populations. All service functions provided by the CLTs will be located in clinics based in HLCs or provided to patients in their own homes, where appropriate. The CLTs will cover the same local population as the Primary Care Locality Teams (PCLTs).  CLTs will provide the vast majority of adult community service contacts across a wide range of professional disciplines. These teams will comprise of a core team of multi-skilled generic nurses and therapists, who will be based in HLCs and supported by the specialist teams. In order to develop integrated working within each locality, the Provider will ensure that the CLTs establish close, formal links with professionals from other external organisations, including (but not limited to): primary care, social care, public health, voluntary and third sector, mental health, pharmacists and the secondary sector. CLTs will work closely alongside all of these organisations to proactively manage and respond to the health needs of the local population. Staff from the CLTs will also actively input into the Integrated Locality Reviews (ILRs).  More detailed information about the CLTs and the specialist services functions can be found in the core service specification (Part 2) and the specialist service specification (Part 3). Both of these documents should be read in conjunction with this document.  2.1.4 Simplifying service configuration  Within the revised adult community services model, CLTs will be developed to make better use of resources. Previously individual services were delivered by a large number of separate teams and groups of professionals, which led to fragmentation and unnecessary complexity. Some services worked in isolation with little integration or co-ordination across organisational boundaries or teams. By simplifying the service configuration, it is expected there will be fewer but larger teams, providing the same range of service functions. The move towards fewer but larger teams will help facilitate a reduction in unnecessary contacts and will improve co-ordination of care. The Provider will be expected to deliver the same range of service functions within the new service configuration.  In line with the Medway Model, the Provider will configure service functions against the six localities, only centralising them if it is not clinically or financially viable to provide them at this level. To this end, the Provider will consider the learning from the NHS New Models Vanguard sites which take into account the feasibility of delivering certain service functions based on population size.  2.1.5 Arranging services into three tiers  As part of the procurement process the Commissioner will work with potential Providers to fully determine the final configuration of service functions based on the needs of each area. Following contract award, the preferred Provider will be expected to use innovative approaches to continue to respond to changes at a local level throughout the term of the contract.  The following tiers will form the basis for the delivery of all services functions:   * At Tier 1 are the most common service functions that support the highest number of patients. These will be provided either in the patient’s own homes (including care homes) or in each of the HLCs which serve the population of each locality (between 30,000 to 50,000 people). Examples of service functions provided at this level are day to day management of long term conditions (including respiratory, cardiology and diabetes), wound therapy, phlebotomy, medication administration, non-bed-based end of life care, physiotherapy and occupational therapy. These functions will be provided largely by members of the CLT within each locality. * At Tier 2 are the service functions that are not feasible to be provided frequently in every HLC, in each locality due to the level of demand or where specialist staff, equipment or clinic space is required. Instead, these will be provided to populations of between 80,000 and 100,000 across two adjacent localities, for example Gillingham or Rainham, Chatham Central or Lordswood, and Rochester or Strood. An example of service functions provided at this level includes gym-based exercise and rehabilitation and group education i.e. structured diabetes education course. * At Tier 3, are the most specialist service functions. Due to the specialist nature of these service functions, it is not feasible to provide them across all six localities. It is therefore, the responsibility of the Provider to ensure that the location of clinics is based on local demand. This level of provision includes the most specialist adult community services where staff will hold smaller caseloads and focus on providing education and clinical support to patients as well as to the multi-skilled, generic nurses and therapists who are providing care to patients in the above tiers. Examples of service functions provided at this level include clinics with specialist nurses (i.e. continence care, tissue viability and epilepsy), hand therapy, and musculo-skeletal services. This tier also includes the specialist palliative inpatient care provided at the Wisdom Hospice.   Figure 1 (below) depicts the arrangement of services in the model and is described in more detail.    As this level of service provision will be provided based on the need to see a specialist, it is likely that patients will have to travel to a HLC outside of their immediate locality to be seen. The frequency and location of these clinics will be determined according to where the greatest need is identified. It is expected that a much smaller number of patients will require specialist care. Patients who are considered to be housebound will receive these services in their own homes.  Regardless of tier, the Provider will ensure that wherever possible, staff will travel to the relevant HLC to provide clinics, (to reduce travel times for patients) or be available through better use of technology, to offer support and treatment to patients in their own homes (including care homes) if they are housebound.  2.1.6 Changing the setting for community services  *Home Visits*  A fundamental aspect of the Medway Model is to deliver care in, or as close to home as possible. Historically almost half the face-face contacts relating to adult community services took place in patients’ own homes (including care homes).  The Provider must ensure that patients are seen in the most appropriate location and should flex resource where necessary in order to achieve this. Home visits can be carried out for patients but only when they are needed and only for those who meet the clearly defined ‘housebound’ criteria that is standard across all service functions. Patients should not be seen at home to make up for any shortfalls in clinic capacity or lack of transport.  The term ‘housebound’ means that a patient is physically unable due to illness or surgery to leave their home. A patient’s ‘housebound’ status can vary over time, and the definitions listed in the glossary of terms reflect these different situations.  Each patient’s eligibility for a home visit will be individually determined by the Provider (based on the definitions in the glossary of terms) and patients assessed as not meeting the housebound criteria will be expected to attend a clinic in the community. Individual circumstances will be monitored and if the patient’s needs have changed, the patient’s housebound status will be reviewed.  The Provider must ensure that all staff are adequately trained to understand and adhere to the housebound definitions when triaging patients, to ensure they receive care in the right location.  The Provider will configure service functions to minimise unnecessary contacts, following the Making Every Contact Count principles. The Provider will, therefore, have a coordinated approach to booking home visits (see central co-ordination function below) ensuring that multiple visits from different professionals are minimised. The Provider will offer patients who are eligible for home visits, set time slots so that they know when professionals are due to visit.  *Contacts in the Community*  For the remaining face to face contacts, that are provided in community settings, the Provider will ensure that wherever possible care will be provided closer to home by moving clinic contacts to the appropriate locality, based on local need.  Currently, around 50% of contacts are provided in a setting that is outside of the locality in which patients live, and often results in patient’s having to travel to another locality to receive treatment. In line with the tier structure outlined above, the Provider will ensure equitable access to services across each of the six localities to meet local demand, which will help to reduce travel times for patients.  Patient Transport Services (PTS) are co-commissioned across the whole of Kent and Medway and sit outside the scope of adult community services. However, the Provider will be expected to link with the PTS service so that patients understand how the service operates and to ensure that adult community services are well served by it. In addition, the Provider will work with the local VCS organisations that operate volunteer-delivered transport services, to facilitate access to these services where appropriate, for example, if patients fall outside the PTS eligibility criteria. By working with both PTS and volunteer-delivered transport services, the Provider will be able to maximise clinic access and embed the housebound criteria by ensuring patients receive care in the right location.  Whilst enhancing equality of service provision across localities and reduced travel times, the Provider must also ensure that patient choice is maintained. Where it is more convenient for a patient to be seen outside of their locality due to work commitments, patient choice or preferred location will preside, and choice will not be limited, for example for phlebotomy or wound clinics.  2.1.7 Realignment of hospital activity to the community  In line with national and local strategy, the adult community services model will help to reduce pressure on secondary care by supporting the realignment of resources across the local system from the hospital into primary and community services. In order to enable the realignment of hospital activity into the community, greater support and resilience is required in the community. The Provider will proactively work with Medway NHS Foundation Trust (MFT) to create stronger links between community services and secondary care; working together to develop proactive in-reach and out-reach.  2.1.8 Location of estates  At the time of writing, the Medway Local Estates Strategy is being updated (and is expected to be finalised by September 2018) to ensure that estates enable the building of resilience and growth into the local system and to deliver the new models of care outlined in the FYFV. The development of the HLCs is fundamental to the Medway Model to ensure that the scale and configuration of space in each centre is suitable for clinical work and supporting activities.  Currently there are still a number of clinics and face to face activity provided outside of the HLCs, in alternative community settings and space within the HLCs is not fully utilised. In line with the developing estates strategy and the Medway Model, the Provider will be expected to locate clinics and other patient-facing services in the HLCs, unless agreement has been sought from the Commissioner to provide the services from alternative sites. The Provider will be required to maximise the current estates, making best use of the space and resources available.  Working with the local authority through the One Public Estate Programme, there are plans to build new facilities in Chatham Central and Strood localities. The expectation is that these two additional HLCs will be in place during 2020-21. During this period, the Provider will be required to operate from alternative sites within the Chatham Central and Strood localities, as an interim measure until the new buildings are completed. Thereafter, the Provider will transfer services from the alternative sites into the new HLCs.  **2.1.9 Improved Access to Services**  Within the service model for adult community services, a central coordination function, extended hours and urgent response are key requirements of the model. The main features of these functions are outlined below:  2.1.10 Central co-ordination function  In order to better manage appointments and improve access to service functions, the Provider will put in place a central co-ordination function that will be available to those patients that need it seven days a week, 24 hours a day. This function will be available through a range of channels and will make it easier for patients to make appointments and /or change appointment details if necessary, at any time of day.  The Commissioner will not prescribe how the central co-ordination function is designed but the Provider should follow the key principles outlined below to enable patients to obtain the correct support through a single telephone number and /or an email address.  The central co-ordination function will be staffed by individuals, who will have detailed knowledge of all service functions within each of the six localities and will be able to respond to general enquiries as well as arrange and book appointments, including time slots for housebound patients. Staff within the central co-ordination function will be able to filter enquiries for specific service functions to the relevant community professional. Based on the Making Every Contact Count principles, clinic appointments will be co-ordinated to minimise the number of trips patients must make; or minimise the number of home visits. By having a full overview of all contacts, the central co-ordinated function enables patient’s care to be co-ordinated to help reduce fragmentation.  The Provider will also ensure that the central co-ordination function is linked to and supported by a patient portal. The patient portal will enable access to key information in one central place; patients will be able to see their Integrated Management Plan (IMP), test results, letters from health professionals, notes, appointment details and self-care apps, giving them more control over their care.  2.1.11 Extended hours  The CCG want to commission a service that offers more flexibility particularly for those patients who work conventional hours and have limited choice of appointment slots. On this basis, the Provider will be expected to offer patients extended access (i.e. out of office hours) for appointments, where demand exists.    The Provider will not be expected to run all service functions at all times, however, where demand exists and in agreement with the Commissioner, the Provider will ensure extended access between the hours 8.00am to 8.00pm Monday to Friday, this will also include weekend provision. Whilst the final operating hours of services will be agreed as part of the procurement hours of operation will be extended to align with Primary Care where possible – for example 8am to 8pm Monday to Friday, Saturday from 9am to 4pm, and where demand exists on Sunday.  The Provider will liaise with primary care and secondary care to ensure that adult community services are able to compliment the developments in improved access (including extended hours) across the health care system. At the time of writing, the CCG is working with all GP practices across Medway to facilitate the provision of additional hours in the evening and at weekends as part of the ‘Improving Access to General Practice’ requirements by October 2018.  For all other services provided outside of these hours, the Provider must work with the Urgent Treatment Centre and Out of Hours Face to Face Services to agree pathways to ensure a seamless service is in place, with no gaps in provision.  2.1.12 Urgent response function  An urgent response function is a key component of the revised adult community services model. The Provider will ensure that, where a case is deemed as urgent, community services respond within two hours. The definition of urgent response can be found in the glossary of terms.  The urgent response function will be accessed via the central co-ordination function. It will be available to support and manage primarily the most complex patients (i.e. those with three or more long term conditions or have complex conditions and are assessed as being high clinical risk) by following a robust triage process to easily identify those who are in crisis, to avoid conveyances to hospital and attendances at the emergency department. Health and social care professionals will also be able to directly access the service for advice, guidance and information.  The Provider will ensure that all patients have an electronic Integrated Management Plan (IMP) that can be accessed to support the urgent response function, to help inform decision making and triage. The most complex patients will have an assigned named Senior Community Clinician as the point of contact for any queries the patient, or their family or carers may have. To provide consistency and continuity of care, the Provider will ensure that those patients, who have a named Senior Community Clinician will where possible, receive an urgent response from their designated named clinician or a member of their local clinical team. Where this is not possible, patients will still receive an urgent response within two hours from a clinician appropriate to the patient’s needs.  The outcome of the triage process for all callers requesting an urgent response will follow formal pathways agreed between the Provider and other relevant organisations i.e. primary care, social care, public health (e.g. health improvement, substance misuse), Out of Hours Face to Face Services etc. This means that for some patients, the two hour response will help to resolve issues the same day (supporting reduced attendances or admissions to hospital). All patients will receive a response to their immediate needs. When there is a significant change in a patient’s condition or they deteriorate or other issues arise, their named Senior Community Clinician will refer them back to the Integrated Locality Review (ILR) for their IMP to be reviewed and updated.  In addition to the above, the urgent response function will also provide access to the relevant specialists to assess and treat early onset exacerbations of long term conditions. The Provider will ensure that strong links to specialist support from acute consultants are in place so that high-risk patients have robust management plans and access to standby medications to support home treatment during exacerbations.  2.1.13 Improved knowledge of wider community assets  The Provider must ensure that their workforce, within the central co-ordination function and more generally have a good knowledge and understanding of the roles, responsibilities, and services provided by other organisations, including health, social care, public health (health improvement services, substance misuse services etc) and the voluntary and community sector, i.e. care navigators. The care navigation service sits outside of the scope of this service specification but the Provider will establish strong links with the care navigation service as one of the key stakeholders within the ILR.  In conjunction with the above, the Provider will also be expected to maintain a comprehensive directory of services to enable a proactive approach to signposting to services for both professionals and patients. The Provider may choose to offer this in-house or develop alternative arrangements with an external organisation to provide this function.  **2.1.14 Improved co-ordination of care**  Within the adult community services model, improved co-ordination of care is a fundamental aspect of the model, in terms of improved sharing of patient information, community locality team working and proactive identification of patients with complex conditions. The main features of these functions are outlined below:  2.1.15 Improved sharing of patient information  In order to improve the coordination of patient care, the ability to share electronic patient information between organisations is essential. The Provider must therefore, ensure that their IT systems are integrated and fully interoperable with those used by GPs, to enable improved communication and flow of information, and reduce the need for non-electronic correspondence.  2.1.16 Community Locality Team working  The Provider will be expected to establish larger core teams at the locality level; to help reduce fragmentation of services, reduce patient transfers between functions, and to reduce duplication. In addition, within each locality the Provider will develop closer relationships with other professionals internally and from external organisations to facilitate closer working within Community Locality Teams.  2.1.17 Patients with multiple long term and complex conditions  The most complex patients i.e. those who have three or more long term conditions or have complex conditions and are assessed as being high clinical risk, are to be identified and reviewed in the ILRs. Patients who fall into the complex conditions cohort will also include, but not be limited to the elderly and frail, patients with additional mental health issues, patients with complex dementia, frequent service users and patients who have a learning disability.  By working with GP practices, social care and other organisations (where appropriate), the Provider will proactively support the identification of people with long-term, complex conditions to ensure they receive appropriate treatment or interventions to keep them well and able to remain in their own home.  \*(*It is estimated that there are approximately 12,500 adults in Medway who fall into this category*).  2.1.18 Integrated case management for people with multiple long term and complex conditions  The Provider will use integrated case management at a locality level for patients identified, and others that are identified or referred from health or social care professionals.  All patients identified for integrated case management will have a single Integrated Management Plan (IMP). Although this cohort of patients may receive care from and be known to a number of service functions, as well as other organisations, the IMP will be accessible to all community professionals, for them to update as necessary.  The Provider will ensure that patients identified for integrated case management will be assigned a named Senior Community Clinician to be the point of contact for any queries the patient, or their family or carers may have. Based on the over-riding care need of the patient, the Provider will determine the most appropriate community professional to be assigned to patients on an individual basis; this could be either a nurse or therapist.  The Provider will ensure the named Senior Community Clinician will be the lead co-ordinator of care and will regularly monitor and adjust levels of support (as specified in the IMP) for individual patients on their caseloads. Where there have been changes to a patient’s treatment or care input, as a result of deterioration or exacerbation in their condition/s, the named Senior Community Clinician will take the IMP back to the Integrated Locality Review (ILR) for update and amendment, where necessary.  The Provider will ensure that there are mechanisms in place to fully support the ILRs across all six locality areas. Regular attendance by staff i.e. the named Senior Community Clinician, specialist staff, consultants and GPSIs at these meetings is essential to ensure information sharing across both internal and external organisations.  One of the key requirements of the Provider, will be to maximise opportunities for better management and support during exacerbations in their conditions. The Provider must therefore, ensure that this cohort of patients is able to access support seven days a week, 24 hours a day from the care co-ordination and urgent response functions, if required. It is anticipated that this additional support during exacerbations in their conditions will help to reduce conveyances and attendances at hospital.  **2.1.19 Focus on prevention and empowerment**  The Provider will ensure that in line with clinical guidelines, patients are offered informed consent and a choice of self-care options to help them better manage their long term conditions. All patients should be assessed to identify which options (based on an individual’s needs, capabilities and preferences) are the most appropriate to help them self-care.  Self-care options should include a range of different choices that promote self-care and enhance general wellbeing, including accessing support in the community i.e. the use of a directory of services to inform and sign-post patients to other services including self-help groups and organisations available in the local area.  At every contact with the patient, opportunities to talk about and support the patient to make healthy behaviour changes are discussed, brief intervention carried out (where appropriate), and signposting  2.1.20 Patient activation  The Provider will ensure that community professionals have an understanding of a patient’s level of knowledge, skills and confidence (or activation level) in relation to their condition. Providers should employ the self-care continuum principles to understand where individual patients are, in terms of willingness and ability to self-manage, so that the most appropriate options are offered to help them manage their condition. The Provider will ensure that this is reviewed on a regular basis to support patients’ needs.  2.1.21 Person-centred approach  The Provider must ensure that community professionals take a holistic approach when assessing and care planning, seeking input from other key organisations i.e. social care and mental health colleagues whenever necessary. When a patient has a range of physical health conditions, mental health conditions, or social care requirements, these will be considered simultaneously. The person-centred approach will be further supported by the co-location of professionals from other organisations in each of the HLCs and ILRs in each of the localities.  The Provider must recognise the importance of parity of esteem between physical health and mental health. The Provider will ensure that community professionals work collaboratively with professionals from mental health to promote people’s emotional wellbeing and help prevent possible crisis. In addition, the Provider will ensure that community professionals are aware of and encourage patients to access support with their mental health. This may include talking therapy services where appropriate i.e. to help patients develop coping strategies to deal with anxiety related to their specific condition. By having access to this additional support, patients will be able to better manage their long-term conditions. The provider will ensure the workforce is appropriately trained in recognising, talking about and undertaking brief advice, interventions and signposting around mental wellbeing (for example attending Connect 5 training).  The Provider will ensure that when assessments and integrated management plans are developed, recognition of the importance of the role family and carers play in providing support to patients should also be included within the plan. For example, this might include the provision of education and advice regarding the cared-for person, as well as directing the carers to services in the community that can support their own wellbeing. The Provider must ensure that pathways to refer to adult social care for a formal carer assessment where appropriate are used.  2.1.22 Prevention and health promotion  The Provider will take a two-pronged approach to prevention and education, by developing strong links with a range of organisations including Public Health to ensure opportunities to prevent ill health are embedded across the local community. Public health services include “A Better Medway” health improvement services, including weight management, smoking cessation, physical activity and exercise referral, NHS Healthchecks, mental wellbeing, substance misuse and sexual health services. The provider will work with public health (and other VCS organisations) to ensure patients are aware of services that promote healthy lifestyle choices and support them to change healthy lifestyle behaviours. This will include:  • working with public health to identify and use referral/signposting pathways between community services and public health services  • developing the skills of community services staff to be able to provide brief advice, signposting and (where appropriate) brief intervention around prevention/public health including attending Making Every Contact Count (MECC) training and having a nominated “A Better Medway” champion  • engaging with “A Better Medway’s” workplace health programme to support and improve the health and wellbeing of staff  • Supporting public health campaigns to improve the health of patients under the care of community services  It is expected that the Provider will also develop innovative links with schools and workplaces to share information about healthy lifestyles, and offer access to educational resources to raise awareness of these programmes.  Alongside primary prevention, the Provider will be expected to offer patient education and activities that promote healthy lifestyles alongside secondary prevention and the self-management of conditions, for example increasing the provision of cardiac rehabilitation classes for patients who have suffered a cardiac event. The provision of educational materials and classes to increase a patient’s understanding of their condition(s) will give patients more confidence and control over their care and enable them to better self-care, so they remain well. The Provider should ensure patients are guided to access this support in the community from a range of statutory, voluntary and community groups.  2.1.23 Improved offer of Technology Enable Care Services (TECS)  The Provider will ensure that patients are given the opportunity to use technology enabled care services (TECS), including telehealth, teleconferencing and self-care apps, which will improve accessibility for those patients who are able to take advantage of these tools, while recognising that they will not be appropriate for everybody.  The Provider will offer TECS to improve access to services for patients and professionals, as well as make service delivery more efficient. A range of TECs should be offered to support the whole population across all health conditions, as indicated below (this list is not exhaustive):   * Telehealth * Telecare * Teleconsultation * Tele-coaching * Self-care apps   The Provider must consider a patient’s capability and propensity to access these services whilst recognising that alternative options must also be available, as one size does not fit all. For people who have never used digital technology and never will, phone support will be needed. However, for people who are confident or expert in using digital technology, self-care apps will be an option.  **2.1.24 Realigned and upskilled workforce**  Within the adult community services model, a realigned and upskilled workforce is key to the successful implementation of the model. Key features include: access to specialist advice and support, core generalist functions and an increased prescribing capacity amongst the workforce. The main features of these functions are outlined below:  2.1.25 Access to specialist advice and support  Although the provision of specialist interventions from consultants and GPs with a Specialist Interest (GPSIs) is outside the scope of this specification, the Provider will need to work in close partnership with secondary care to access their expertise in the community. For example, better use of technology i.e. use of teleconsulting will help provide access to specialist advice and support.  2.1.26 Core team of generalist nurses and therapists  The Provider will ensure that the larger group of core generalist nurses and therapists are a more resilient workforce and have a shared set of skills that helps reduce duplication and transfers of patients between service functions. The Provider will ensure that this cohort of staff are appropriately trained to carry out interventions relating to the most prevalent health conditions to support people with long term conditions. This means that because nurses and therapists will have a wider, more generalist skills set, they will be able to support patients with several long term conditions i.e. diabetes and COPD rather than just managing patients by separate disease groups.  The Provider will ensure that these core generalist nurses will work alongside and be supported by specialist support clinicians who can provide advice and education, as well as more complex interventions when required.    2.1.27 Increased prescribing capacity  The Provider will ensure that the required non-medical prescribing resource is available to ensure that patients are provided with a prescription for two weeks’ worth of any recommended treatment to prevent a delay in patients starting treatment.  The Provider will adhere to the Medway and Swale Formulary and will work closely with the CCGs’s Medicine Optimisation team to ensure safe, cost-effective, evidence-based and rational prescribing. The Formulary is updated regularly therefore it is essential that it is frequently consulted. Where local guidelines are not available, prescribing or recommendations to prescribe must be in line with NICE Clinical Guidelines. | | | |
| **3.** | **Desired Outcomes** | | |
| 3.1 | Outcome list (for patients and wider system) linked to KPIs as relevant | | |
| The Provider will contribute to and be judged on the NHS Outcomes Framework across all of the domain areas. In addition, the Provider will contribute to the Adult Social Care and Public Health Outcomes Frameworks. Specific indicators will be determined at a later stage.  The Provider will contribute to and be judged on the following whole-system outcomes. Specific indicators will be determined at a later stage.   * A greater proportion of care takes place at home or in community settings, in line with the Medway Model. * A culture of collaborative, patient-centred care that transcends historical boundaries of care setting, organisation or budgetary responsibility. * A resilient, competent and empowered workforce where skills are effectively shared across services and organisations * A digitally enabled system where patient information flows in secure and timely manner, including the development of a single care plan for those with multiple needs. * A system that intervenes as early as possible to promote health, well-being and independence and enables people to manage their conditions * Well-developed links with the VCS and wider community organisations and professionals are better equipped to help people access not clinical services in the community. * GPs find community services responsive and effective with timely communication and information sharing. * A reduction in admissions, readmissions and avoidable admissions to hospital. * A reduction in length of stay in hospital. * A reduction in ED attendances. * Seamless care for people at the end of their life. * Whole-system developments are supported by more robust and accurate qualitative and quantitative information. * Development of pathways that link with wider public health initiatives.   The Provider will contribute to and be judged on the following patient outcomes. Specific indicators will be determined at a later stage.   * People, patients, carers and families have an overall positive experience of care. * People have an equitable experience irrespective of their age, gender, sexual preference, or where they live. * People can access services in their local area and at home when they are unable to leave the house. * People can access services in the evenings and weekends and services are responsive when people are in crisis. * People can access services through a single point of access and the scheduling of appointments is well-coordinated. * People have access to their IMP (via a patient portal) which will give them greater understanding and control over their care and know who to speak to if an urgent response is required. * People are able to remain well through a greater focus of prevention and self-help within community services. For example, people are aware of and referred/signposted to health improvement services in Medway and feel supported to access a range of non-clinical support from VCS and local community groups. * People have their needs considered in a holistic way, taking into account all aspects of health and wellbeing, to achieve positive health outcomes. * People have trust and confidence in community services staff and are treated with dignity and respect. * People feel that they have sufficient time with the professionals that they know them and not just their clinical needs. | | | |
| **4.** | **Service standards and best practice** | | |
| 4.1 | Compliance with guidance, standards and best practice | | |
| 4.1.1. The Provider is responsible for ensuring that all clinical staff practice and operate in accordance with the most recent standards and guidelines for their particular area of specialty. The Commissioner will work with the Provider to ensure evidence of best practice is followed at all times.  4.1.2 The Provider is responsible for ensuring that all clinical staff abide by NICE guidelines. | | | |
| **5** | **Scope and accessibility** | | |
| 5.1 | Inclusions and exclusions (geographical/ GP register restrictions, age, conditions/ thresholds) | | |
| 5.1.1 The Provider will provide the service to patients who are registered with a Medway GP.  5.1.2 Unregistered patients living in Medway should have equitable access to service functions and should be encouraged and supported to register with a GP.  5.1.3 Referrals for patients registered with a GP practice in another CCG area, should be directed to the equivalent commissioned services in that local area. The Provider will comply with Service Conditions (as part of the NHS Standard Contract) in relation to patient choice.  5.1.4 The Provider will ensure treatments offered will be in line with the Kent and Medway Referral and Treatment Criteria.  5.1.5 Further detail regarding the points below, will be given in the final specification:   * Age restrictions for specific service functions * Clinical exclusions for specific service functions * Service Conditions (as part of the NHS Standard Contract) relating to equity of access | | | |
| 5.2 | Referral process (referral routes, triage process, discharge process, DNA policy) | | |
| 5.2.1 Detail to be confirmed but the Commissioner will work with the Provider to agree the development of a single (electronic) referral process.    5.2.2 The Provider will have an agreed policy for DNAs and Discharge. | | | |
| 5.3 | Responsiveness and priority levels | | |
| The Provider will provide a 2 hour response – in line with the urgent response function.  All other response times will be detailed in the final specification. These will be in line with best clinical practice and standards. | | | |
| **6** | **Interdependencies** | | |
| 6.1 | Links to other teams in same organisation/ secondary care/ primary care | | |
| The Provider will be required to work collaboratively with a wide range of stakeholders, professionals and health care agencies to optimise positive outcomes for patients; including but not limited to:  6.1.1 Secondary Care Services  Although out of scope of this specification, the Provider will need to work in close partnership with secondary care to access their expertise in the community and to work with them on the development of new pathways and to establish shared care arrangements for particular conditions i.e. COPD, cardiology, diabetes etc. Proactively working with secondary care will help to build seamless provision of care for patients and reduce any overlap of duplication of services.  6.1.2 Urgent Care Services  In Medway the Urgent Care Re-design process is underway and is subject to a separate procurement process. The Provider must consider the interface with urgent care and ensure that the adult community services model compliments the new model for urgent care. This procurement is out of scope of this adult community services specification, but the Provider must work proactively with the urgent and emergency care services to establish robust links and pathways.  Future work areas could include, but will not be limited to:   * The Provider will work with 111 to profile the Directory of Service (DoS) to reflect adult community services provision, i.e. to flag patients with complex conditions on contact with 111. * The Provider will link with SECAmb to ensure information sharing and intra-operability between SECAmb IT systems (IBIS) and the Provider (via the urgent response function) to help support patients to remain at home and avoid conveyance to hospital. * The Provider will work with the Urgent Treatment Centre (UTC) at Medway NHS Foundation Trust (MFT) to review interoperability between the Provider and the UTC, to agree admission avoidance initiatives.   6.1.3 Resilience  All Providers must have in place adequate business continuity plans. All Providers must have in place an escalation plan to deal with periods of surge in activity, most often across seasonal periods such as Easter, bank holidays, winter and Christmas and New year.  In addition to this, Providers are required to participate in the development of the wider Medway and Swale System Escalation Plan as well as adhering to the final system plan. This includes, but not limited to; system escalation processes, embedding and following the latest national guidance for escalation (such as the latest NHS England OPEL Framework), joining mandatory system teleconferences, using SHREWD (description below) and providing a regularly updated indicator set (on SHREWD) to enable real time visibility of escalation within the service provision to all system partners.  The System Escalation Plan and processes are reviewed at least annually to ensure the system remains responsive to and supports swift system recovery during periods of escalation.  6.1.4 SHREWD  SHREWD stands for Single Health Resilience Early Warning Database and is an on-line, real time health system management tool. SHREWD is used across the whole system to provide a real time view of system pressure that clearly shows where an activity has escalated, allowing data driven decision making.  Each provider organisation has a set of agreed SHREWD indicators that are RAG rated and weighted in line with organisation and System Escalation Plans. As part of escalation plans providers are required to set trigger values for each indicator and keep these updated to provide real time visibility of escalation across any area. The indicators are RAG rated using the ‘BRAG’ (Black, Red, Amber, and Green) system which is presented as wheels as visual aids to reflect the pressures. This has been aligned to the new OPEL framework in a simple way that green reflects OPEL 1, amber reflects OPEL 2 and so on.  6.1.5 Adult Social Care  The Provider will be expected to work closely with Medway Adult Social Care to ensure close collaborative working between health and social care. The Provider will work seamlessly with social care teams to ensure regular representation at the Integrated Locality Reviews (ILRs); with social care professionals fully involved in the care planning process for any patients requiring non-acute care in the community.  Domiciliary care services will be reconfigured according to the Medway Model enabling carers to be located closer to the patient’s home. These services will be expected to work in a more integrated way with other local organisations including the Provider (of adult community services); to help support integrated care delivery. They will work closely with the Provider to align and facilitate integrated care planning. This will ensure the needs of patients are more holistically supported in a joined up way, by domiciliary carers working in close alliance with the core generalist and specialist support functions.  A number of services jointly funded by health and social care (via the Better Care Fund) sit outside the scope of this specification, but are integral to the transformation of the local health and social care system. These include (but are not limited to): MICES, the Integrated Discharge Team, Intermediate Care and Re-ablement Services including Home First and services to support informal and family carers. Over the next few years, Medway Council will realign expenditure on traditional institutional style services, such as care homes and day centres into services delivered in people’s own homes and in local communities. The Provider will work alongside social care services to provide a co-ordinated service and a better patient experience. The Provider will ensure adult community services model work seamlessly with those services out of scope of this specification to ensure future provision is designed to cope with the shift of social care out of traditional style care homes to other settings.  The Provider will work with Medway adult social care to consider the crossover/ linkages with the procurement of Home First Plus.  6.1.6 Mental Health Services  It is expected that key link staff, i.e. community mental health nurses, will be an integral part of the Community Locality Teams (CLTs) and will work closely with the core generalist and specialist support functions to share information and monitor changes in a patient’s condition; ensuring robust processes for communication are in place.  6.1.7 Stroke Services  Stroke services in Kent and Medway are undergoing a review, the outcome of which will determine the services required to support the whole stroke pathway. This includes hyper acute, acute and community stroke services. Until the outcome of the review is known, stroke services will remain out of scope of this specification and the Provider responsible for delivering the revised adult community services model will work closely to ensure seamless transition of care between stroke services and other community services.  6.1.8 Care Homes  The Provider will work with care homes, GPs and care home pharmacists to ensure comprehensive support for patients in care homes is co-ordinated and delivered. Staff within CLTs will work with the professionals (listed above) to provide proactive support, medication reviews and an urgent response when required to avoid admission or attendance at hospital.  6.1.9 Reasonable Alternatives  The Provider must ensure that options for patients with visual, hearing or communication difficulties, learning disabilities, mobility issues, without PC/internet technology need to be made available and easily accessible, to enable patients to use the services.  The Provider must ensure that adult community services also link with and make best use of community pharmacies and opticians.  6.1.10 Public Health Services  The provider will work with public health services to ensure close collaborative working between health and public health. Public health services include “A Better Medway” health improvement services, including weight management, smoking cessation, physical activity and exercise referral, NHS Health checks, mental wellbeing, substance misuse and sexual health services. This collaborative working will include:   * working with public health to identify and use referral/signposting pathways between community services and public health services * developing the skills of community services staff to be able to provide brief advice, signposting and (where appropriate) brief intervention around prevention/public health including attending Making Every Contact Count (MECC) training and having a nominated “A Better Medway” champion * engaging with “A Better Medway’s” workplace health programme to support and improve the health and wellbeing of staff * Supporting public health campaigns to improve the health of patients under the care of community services. | | | |
| 6.2 | Shared care protocols | | |
| 6.2.1 The Provider will ensure that the community services operate in a collaborative and seamless way with GPs, Medway Council social care teams and mental health professionals, developing shared care protocols. In addition, the Provider will ensure that community services work closely with other commissioned care providers, including care home staff and domiciliary staff, inputting and collaborating with whole system care home projects and domiciliary care provider forums. | | | |
| 6.3 | Information sharing (electronic correspondence, multi-operability gateways) | | |
| 6.3.1 The Provider will operate a paperless environment - including electronic order communications; and shared care plans with other health and social care providers.  6.3.2 The Provider will ensure that it operates in line with the aims of whole-system digital strategies relating to the development of ICT and will meet the requirements relating to electronic referrals and IT systems outlined in the Service Conditions.  6.3.3 Provider will cooperate, be involved in and share information to facilitate whole-system developments. | | | |
| **7** | **Facilities, equipment and ICT** | | |
| 7.1 | Location requirements | | |
| The provider will, in line with the Medway Model ensure community clinics are located within the HLCs. Utilisation of other clinic space (other than the designated HLCs) will have to be agreed with the Commissioner. This will be necessary in the Central Chatham and Strood area until the new developments planned for those areas are built.  The Provider will also provide services in patients own homes (including care homes) if they meet the housebound criteria. The Provider will be expected to provide regular updates on the location and operating hours across the range of functions provided. | | | |
| 7.2 | ICT hardware, software and intellectual property | | |
| In order for patients to receive co-ordinated, seamless care, it is essential that the Provider has an IT system that is accessible to staff.  It is also imperative that the IT system used by the Provider operates interactively with systems used by other providers within the whole system including primary care, secondary care, social care and the ambulance service in order to support more co-ordinated working and sharing of information.  The Provider will be expected to have in place responsible and robust Information Governance processes in line with the most recent national guidance. | | | |
| **8** | **Workforce** | | |
| 8.1 | Building a workforce for the future | | |
| 8.1.1 Across the whole system, in line with the KMSTP Local Care agenda, the workforce will gradually be deployed differently to support the realignment of resources from the hospital into primary and community services. Recognising that the workforce of 2020 is largely the workforce of today, the Provider will continue to work with the Commissioner and the wider system to meet the changes and challenges ahead.  The Provider will ensure that they have a flexible and adaptable approach to skill mix and workforce, in order for them to be able to accommodate any future changes in service demand. | | | |
| 8.2 | Staff competency requirements | | |
| 8.2.1 The Provider will ensure that its workforce are adequately trained and supported. The Provider will develop a competency framework and training programme to support the management of multiple long-term conditions across all Community Locality Teams (CLTs) to ensure a consistent high standard of general nursing across Medway. The Provider will work with the Commissioner to ensure roles and responsibilities are standardised in line with the different functions of both the core generalists and specialist support functions. The Provider will be expected to produce on request up to date records to demonstrate staff competencies and skills, a workforce training matrix and pathway development plans. The Provider will be required to demonstrate that the workforce have received and are up to date with training around prevention/public health (e.g. Making Every Contact Count training) and are able to have conversations with patients about making healthy behaviour changes and signpost to services for further support. | | | |
| 8.3 | Safe staffing levels | | |
| 8.3.1 The Provider will demonstrate clear methodology (i.e. Risk Stratification Tools) to maintain safe staffing levels at all times. The Provider will have on request accurate knowledge of staffing vacancies, as well as staff recruitment and retention plans. | | | |
| 8.4 | Ongoing training and development | | |
| 8.4.1 The Provider will ensure a clear, comprehensive training and development plan is in place that drives continuous staff development and improvement. It is expected that the training and support provided to the core generalist function by the specialist support function, will be reflected in the Provider’s education and training programme. The Provider will work closely with the Commissioner with regard to specific areas of staff need i.e. skill set shortages in particular staff groups. These discussions will consider options in terms of future developments and local innovation, as well as consider the wider Kent and Medway position regarding workforce developments. | | | |