|  |  |
| --- | --- |
| **Service** | Adult Community Services |
| Specification Reference | Generic Service Specification  |
| Period |  |
| Last Updated |  |
| **1.** | **Introduction and Context** |
| 1.1 | Summary/ Introduction |
| Adult community services are an important component 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 community and voluntary sector (CVS). 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 service specification sets out the high-level requirements of the Provider in relation to adult community services for Medway residents registered with a Medway GP. Within this specification a number of care areas are specifically for Swale residents registered with a Swale GP. These are: - Specialist palliative care, including hospice care- Hand therapy- CAS, MSK and triage- Nutrition and dieteticsIt references generic principles that the Provider will follow across all parts of the service model, which are in line with national policy, best practice and details the links with the core and specialist functions. 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 new service model for adult community services 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 draft 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 provided within the community are within the scope of this specification, the Provider will be required to liaise with the Provider/s of these services to ensure the development of pathways within the remit of this specification, are co-ordinated and holistic. A full list of services that are in scope and out of scope of this procurement are listed in Appendix 1. This document should be read in conjunction with the Key Requirements document as this provides more detail on the core and specialist functions. These 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 and Swale End of Life Strategy
* Urgent Care Re-Procurement
* Medway Health and Wellbeing Strategy
* Medway Local Estates Strategy
* Medway Digital Strategy
* Medway Cares’ Strategy
* Kent and Medway Stroke Review
* Medway Voluntary Community Sector Better Together Consortium
* Well-being Navigation Re-procurement
* Medway Integrated Community Equipment Service (MICES)
* Medway Mental Health Strategy

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 for adult community services, 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 service 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 End of Life strategies for both Medway and Swale.
* Ensuring staff are trained in prevention (e.g.Making Every Contact Count MECC) are able to have conversations with patients about how to make healthy lifestyle changes and are 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 Medway Clinical Commissioning Group’s (CCG) *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. Recent statistics show that:* Medway has a younger population of (25-65yrs) with multiple co-morbidities; some of these have under diagnosed mental health conditions or complex needs
* As a result of poor access to GP services, there are higher rates of urgent care attendances and admissions in Medway
* 24% of hospital admissions could be avoided if alternative services were available in the community

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 12,500 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. Homelessness is a growing issue across Kent and Medway. Due to poor access to service provision, homeless people can have poorer physical and mental health including substance misuse. 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. The Medway Model requires a flexible, dynamic and responsive lead Provider, who will be held to account on the below aims and objectives:**2.1.1 Over- arching aims of the new service model for adult community services 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• A revised m0odel of care and service delivery, utilising evolving best practice• To provide responsive services that can adapt and change in line with changing priorities nationally and across Kent and Medway • A high quality experience of care for patients, their families and carers• Provide safe, high quality evidence based holistic patient centred care• To have effective and efficient management of resources to deliver an excellent standard of service within the financial envelope available• To have a highly skilled and appropriately trained workforce to support the management of long term conditions and provide expert advice to other health care professionals * To have in place a programme of continuous staff development and training to ensure all staff are upskilled in the management of long term conditions

• To improve co-ordination of care, to treat the person, not the condition• To ensure a greater focus on prevention, patient empowerment and ownership; educating and empowering patients to contribute to reducing, where possible, their reliance on services and minimise any re-occurrence or exacerbation in their condition/s. This might include offering brief advice and sign posting to behaviour change services to help optimise independence and wellbeing* 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 • Support people to stay well longer in the community; in order to avoid unnecessary hospital admissions and and attendances at ED from patients with long term conditions where specialist community intervention and support can be provided e.g. respiratory disease, diabetes, heart failure, continence conditions and problems relating to effective wound care.• Assess health care needs and develop/ contribute to personalised care plans in partnership with the patient, and their family/ carers (and other external organisations, as requested) to meet their needs.• Improved access to a full range of specialist staff; that offers a responsive service in accordance with the clinical needs of patients including when patients are in crisis* An integrated approach to working with secondary care specialist services to deliver comprehensive support in the community

• A reduction in the need for long term care through effective preventative care and promotion of self-management**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\*In addition, relevant Swale locations will also be included (to be confirmed at a later date) for the four services outlined above.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 (ILRs). They will work closely with the Community Locality Teams (CLTs) and wider health, social care and (VCS) to ensure the most complex patients within each locality are effectively managed by ensuring personalised Integrated Management Plans (IMPs) 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, CVS will be co-located. This will bring together a range of clinical services, wider health and social care expertise, and the CVS 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 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 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, VCS, 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 ILRs.**2.1.4 Simplifying service configuration**Within the new service model for adult community services, the Provider will establish CLTs to make better use of resources. The Provider must move away from individual services being delivered by a large number of separate teams and groups of professionals, which can lead to fragmentation of provision and unnecessary complexity, as services work 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, but will deliver the model using an integrated and seamless ‘one team’ approach which removes traditional boundaries between individual services.In line with the Medway Model, the Provider will configure service functions in alignment with 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. The Provider will match capacity with expected levels of demand across all service function areas, including predictable fluctuations. 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 home (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 the home (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. Patients who are ambulatory and are able to get to a clinic, should be seen in a clinic location. This position applies as 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 MECC principles. The Provider will, therefore, have a co-ordinated 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 new service model for adult community services 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**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. 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, as specified by Commissioners, 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. The Provider must seek prior approval from Commissioners to change the location of service provision. **2.1.9 Improved Access to Services**Within the new service model for adult community services, a central co-ordination function, extended hours, urgent response and improved knowledge of wider community assets 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. Via the central co-ordination function patients will be able to access an urgent response to prevent inappropriate hospital attendances and admissions. 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 MECC 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 personalised IMP, test results, letters from health professionals, notes, appointment details and self-care apps, giving them more control over their care. Patients will be able to re-arrange their appointment slots via this portal where it is necessary. *2.1.11 Extended hours* The new adult community services model must offer 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. 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 new service model for adult community services . The Provider will ensure that, where a case has been clinically triaged and deemed as urgent, community services respond within two hours. This component of the service requires a rapid assessment by a suitably registered practitioner, and follow on care for urgent health needs, or other crisis in care provision, within a patient’s home (including care home or other supported living facility). The definition of urgent response can be found in the glossary of terms.An urgent response will be accessed via the central co-ordination function. It will be available to support and manage primarily but not exclusively, the most complex patients (i.e. those with three or more long term conditions or have complex conditions and are assessed as being at high risk of admission or deterioration). The Provider will ensure that access to the urgent response function is available 24/7.The urgent response function will: * Prevent potentially avoidable admission of patients to secondary care services by providing rapid assessment, treatment, advice, support and education to individuals in their own home including support, nursing and therapeutic interventions during acute illness, sudden deterioration in function or condition, or crisis in care provision.
* Provide holistic assessment of need and necessary support, equipment and intervention to promote stability in the patient’s condition and enable them to remain in their own home including care home.
* Co-ordinate the multiagency response as necessary to enable the patient to be managed safely at home, including accessing advice and guidance as needed to support decision making and the development of a care package.
* Ensure that patients who are nearing the end of life are supported to receive their final period of care in the place of their choosing by organising the care and interventions needed to support them over 24 hours a day seven days a week in their final weeks of life in line with most recent national framework.
* Include access to rapid assessment within 2 hours, diagnostics and or near patient testing, and an initial care plan or treatment commencement if required within 4 hours of assessment completion.
* Where an urgent care or Emergency Department (ED) attendance is ultimately required, the team should work with the acute or other provider to ensure that the service user can be returned home as quickly as possible where it is safe to do so following X ray or other diagnostic tests.

Health and social care professionals should be able to directly access the urgent care function for advice, guidance and information. The Provider will ensure that all patients have a personalised IMP that is electronic and 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 (SCC) 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 SCC 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, local ambulance service (SECAmb), mental health services and Out of Hours services etc. This means that for some patients, the two hour response will help to resolve immediate issues to avoid exacerbation and enable support to be co-ordinated and put in place to help avoid unnecessary 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 SCC will refer them back to the local ILR for their personalised IMP to be reviewed and updated. The urgent response function will provide access to the relevant specialist nurses and therapiststo assess and treat early onset exacerbations of long term conditions. The Provider will ensure that contractual arrangements are in place with secondary care providers to enable access to specialist support from acute consultants, so that high-risk patients have robust management plans and access to standby medications to support home treatment during exacerbations.In addition to responding to patients in the community in crisis, staff will also provide supported discharge for patients in hospital to enable them to return home with a short-term re-ablement package of care (POC) for up to six weeks. Staff will work with the Integrated Discharge Service at Medway NHS Foundation Trust to ensure that an effective discharge is facilitated. The Provider will need to work with Medway Council to facilitate a POC. The Provider will have the ability to flex workforce across each locality when needed, to respond to urgent requests. Arrangements for sickness and absence cover will need to be clearly defined with a clear process for business continuity.*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, mental health, public health (health improvement services, substance misuse services etc) and the VCS, i.e. Wellbeing 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.The Provider will also be expected to maintain a comprehensive directory of services (DOS) 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. The Provider should work with other local services maintaining a DOS to avoid duplication of effort.**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. The Provider must work with GPs and other partner organisations to ensure that data sharing agreements are in place to support this work. *2.1.16 Community Locality Team (CLT) working*Within each of the CLTs, core nurses and therapists, supported by specialists will work at a locality level; to help reduce fragmentation of services, reduce patient transfers between service provision, and reduce duplication. Staff will support patients within their locality area. The Provider will ensure staff are appropriately aligned according to the health needs of each locality. Within each locality the Provider will develop closer relationships with external partner organisations to facilitate closer working within CLTs. *2.1.17 Patients with three or more long term /or 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 at high risk of admission or deterioration, 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, mental health and other organisations (where appropriate), the Provider will proactively support the identification of people with three or more 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 three or more long term/or 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, personalised 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 view and update following each contact, as necessary. The Provider will ensure that patients identified for integrated case management will be assigned a named SCC 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 SCC will be identified as the person with the most appropriate skills and experience to co-ordinate the community health response and work with the patient and partner organisations to lead the development of the IMP and co-ordinate care for that person, ensuring that it is delivered in the most appropriate setting. The Provider will ensure that as part of the care planning process a range of clinically appropriate interventions are provided, for the level of need idenitified. The Provider will ensure the named SCC 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 SCC will take the IMP back to the ILR for update and amendment, where necessary. The Provider will ensure that community services are embedded as a core part of the wider health and social care system with the Provider working in each locality supporting the ILRs to enable people to remain living at home, including care homes or other supported living facilities, for as long as possible by helping them to reach the best level of ability and independent living that is possible.The Provider must ensure that an appropriate clinical professional attends these meetings 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 of patients 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 should offer innovative ways of providing information, advice and guidance, as well as easy access across a range of channels so that patients can self assess and self manage; helping patients to find their own solutions to things that matter to them is an important part of this care model. The Provider will ensure that in line with clinical guidelines, patients are offered a choice of self-care options to help them better manage their long term conditions. All patients should be supported to identify which options (based on an individual’s needs, capabilities and preferences) are the most appropriate to help them self-care. It is therefore, essential that all staff know what support and advice is available in their local community. 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 to improve and increase access to Well-being Navigators.The Provider will ensure that front-line staff offer (as appropriate) brief interventions on a range of topics, as well as being aware of the referral routes into services that can provide more targeted support. Interventions will be based on strong evidence and examples of good practice, including National Institute for Health and Care Excellence (NICE) guidelines and Public Health England policy and practice guidance.*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 personalised IMPs 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 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 servicesIt is expected that the Provider will also develop innovative links with employers and educational organisations 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. *2.1.23 Improved offer of Technology Enable Care Services (TECS)*The Provider will ensure that patients are given the opportunity to use 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 new service model for adult community services, 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* While the roles of specialist staff will be primarily focused on a specialty, the Provider will ensure that they can provide care across and outside their specialties as follows: where the patient has needs within their competence and capacity, where patient needs demand it, and where it is practically possible in order to avoid multiple visiting or duplication. The Provider will develop clear pathways to enable access to this specialist advice and support, as part of the workforce/model development. *2.1.26 Core team of generalist nurses and therapists*The Provider will ensure that the core nursing and therapy staff are a more resilient workforce, with 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, skill 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 nurses and therapists will work alongside and be supported by specialist clinicians who can provide advice and education, as well as more complex interventions when required. The Provider will ensure that staff have the relevant skills and awareness training to holistically support patients with (not limited to): mental health, learning disabilities and dementia. This can include signposting to support services i.e. Talking Therapies (IAPT services) or referral to the Well-being Navigation service. *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.** | **Applicable Service standards and best practice** |
| 3.1 | Compliance with guidance, standards and best practice |
| 3.1.1. The Provider must adhere to all national and local standards as applicable in relation to service delivery and to all requirements within the contract . It is responsible for ensuring that all clinical staff practice and operate in accordance with the most recent standards and guidelines. The Commissioner will work with the Provider to ensure evidence of best practice is followed at all times.The following sections provide examples only and should not be considered exhaustive.**3.1.2 Applicable National Standards and Guidance (e.g. NICE) – including but limited to the following:**• Care Act 2014• Mental Health Act 2009• Continuing Health Care National Framework 2012 (or latest versions)• Care Quality Commission Registration Requirements• National Safeguarding Guidance, Policies and Procedures• Making Safeguarding Personal• Department of Health Guidance• National Services Frameworks (NSF), where applicable i.e. Older People• The current Operating and Outcomes Framework for the NHS in England• Relevant NICE Guidance• Mental Capacity Act 2005 • Safe, compassionate care for frail older people using an integrated care pathway, NHS England, practical guidance for commissioners, providers and nursing, medical and allied health professional leaders, February 2014• Care in Local Communities - A new vision and model for district nursing – DoH (Jan 2013) • Transforming Community Services – Quality Framework (2010)• Care Quality Commission: Essential Quality Standards of Quality and Safety (2010)• Common Core Principles for Supporting People with Dementia (2011)• The Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidelines (2010)• The Health and Social Care Act 2008 (Regulated Activities) Regulations (2014): Regulation 20 Duty of Candour• Disclosure and Barring Checks• Mental Health Capacity Act (2008)• Deprivation of Liberty Safeguards (2009)• Making a Difference in Dementia: Nursing Vision and Strategy (2013)• NICE Quality standards for dementia (Dementia: support in health and social care/ dementia: independence and wellbeing)• The Controlled Drugs (Supervision of Management and Use) Regulations (2013)• Human Medicines Regulations (2012)• Serious Incident Framework (2015) http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf• National Patient Safety Agency (2010) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. Available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173 • Working Together to Safeguard Children (2013)• NHS Employment Check Standards (2013)• Workforce Race Equality Standards (2015)• Accessible Information Standard (2016)• Public Services (Social Value) Act 2013• NICE (2015) Guideline [NG27] Transition between inpatient hospital settings and community or care home settings for adults with social care needs**3.1.3 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) -** **including but not limited to the following:**• Royal College of Nursing Guidelines • Nursing and Midwifery Council (NMC) Codes of Conduct, Professional Guidelines and Standards• Health and Care Professions Council Standards of Conduct, performance and ethics, proficiency, education and training, continuing professional development, and prescribing.• Professional standards of:* Chartered Society of Physiotherapy
* British Association of Occupational Therapists
* BDA The association of UK Dieticians
* Royal collage of Speech and Language Therapists
* Health Protection Agency – providers of support and advice

• Ready to Go: Planning the discharge and transfer of patients from hospital and intermediate care (DH 2010)• Immunisation Against Infectious Diseases (DH 2006) plus updates via http://www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyandGuidance/DH\_079917 **3.1.4 Applicable local standards - including but not limited to the following:**• All relevant local NHS policies and procedures. The Provider must be CQC registered at the level and standards required by the CQC. • Any other as appropriate to the services/staffing• As set out in Contract and in relevant Contract schedules• Medway Safeguarding Adults and Children policies and procedures• Local governance policies and procedures • Infection, prevention and control guidance and reporting• CCG prescribing guidelines, policies and commissioning statements |
| 4.0 | **Applicable Quality Requirements** |
| 4.1 | Compliance with guidance and standards |
| The contents of this section are in addition to any requirements within the Contract, particularly in Schedule 5: Part A national operational standards, Part B national quality requirements and Part C Local Quality and outcome requirements (KPIs), and where there is any inconsistency the more onerous requirements will apply.**4.1.1 Applicable Quality and Safety Requirements** The Provider will be CQC registered and meet all of the essential standards of quality and safety set out by the Care Quality Commission (or any successor organisation) at: [www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm](http://www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm)The Provider must work to prevent and or reduce the risk of avoidable harm, and must have in place governance systems and processes within its infrastructure to support this. The Provider must ensure that the safety of patients accessing services is paramount. All relevant DoH and NHSE guidance on preventing avoidable harm apply to this service.The Provider will have in place a range of safety policies and procedures, which must comply with current legislation. The Provider will ensure that all staff receive the required training and instruction in all such policies and procedures, and evidence of this compliance should be made available to the Commissioner on request. The Provider will ensure all safety incidents are reported to the Commissioner using agreed processes. The Provider will be expected to report all Serious Incidents in line with the NHS Serious Incident Framework 2015 and to manage or co-operate as appropriate in all investigations undertaken. The Provider will be expected to comply with all infection, prevention and control guidelines including the appropriate reporting and investigation of Healthcare Associated Infections (HCAI) in line with NHS England and Public Health England Guidance. The Provider should ensure it has access to specialist infection prevention and control advice as deemed appropriate to fulfil its obligations.The Provider will demonstrate systems, policies and procedures for risk assessment, risk management, investigation and learning lessons from incidents. The Provider will have in place Business Continuity plans, emergency response and complaints policies.**4.1.2 Service User Safety**The Provider must have effective and robust risk management systems in place for reporting, investigating and learning from patient safety incidents. All patient safety incidents will be reported to the National Patient Safety Agency (NPSA) (now part of NHSI) electronically via the National Reporting and Learning System (or any successor organisation or system). All documentation relating to incidents must be made available on request for scrutiny by the Commissioner.The Provider will disseminate, implement and evaluate all NPSA and Medicine and Healthcare Products Regulatory Agency (MHRA) guidance disseminated via the Central Alert System (CAS) including service user safety alerts and other safety solutions and products developed for the NHS in a timely manner . Where the guidance and/or alert have specified timeframes, the Provider must work within these.The Provider will be expected to comply with the requirements of the Safety Thermometer as a contractual requirement. The Provider will be expected to have a clear policy and plan for regular clinical audit and a process for embedding learning as a result.**4.1.3 Incidents and Serious Incidents**The Provider is expected to work with the Commissioner to ensure implementation of all standards that are included within the latest relevant National Framework including reporting via the Strategic Executive Information System (STEIS). The Provider is required to share with the Commissioner any report relating to a serious incident that may be required by external bodies.The Provider shall discharge the duty of candour in line with the regulation contained within the Health and Social Care Act (2008), (Regulated Activities) Regulations 2014.The Provider shall attend the local serious incident review panel and engage in any relevant local and regional events.**4.1.4 Never Events** If, and each time a Never Event occurs, the Commissioner will (without prejudice to any other rights or remedies) apply the Never Event Consequences set out in the Contract applicable to the Never Event in accordance with relevant Guidance.The Provider will report all Never Events as Serious Incidents to the Commissioner as outlined in the up to date NHS policy framework.  **4.1.5 Safeguarding of Children and Adults** Although the service is focused on adults, as a provider of community services and one who will see and care for children in some aspects of the service, staff will come into contact with children including family members and those who are transitioning to adult services. The Provider must have in place systems and processes that comply with multiagency policies and procedures as part of the local Adult and Children’s Safeguarding Boards. The Provider will comply with the quality requirements and key performance indicators (specified within the contract) for safeguarding.  |
| **5.0** | **Prescribing and Medicines Management** |
| 5.1 | Medicines Management |
| The Provider will have appropriate monitoring systems in place to assure the Commissioner that all relevant legislation, regulations and good practice guidance pertaining to the storing, prescribing, administering and supplying of medicines are adhered to for all commissioned services.The Provider will participate in the local Drug and Therapeutics Committee (or equivalent) in place to co-ordinate Medicines Optimisation.The Provider will work within the boundaries of the Local Formulary <http://www.medwayswaleformulary.co.uk/> and will adhere to and practice within the remit of the Medicines Optimisation Interface agreement. The Provider will be expected to evidence adherence to formulary. The Provider must ensure that generic prescribing is used unless it is clinically inappropriate. Prescribing by medical and non-medical staff will be monitored by the Provider through ePACT data analysis and clinical audit; the Provider will be responsible for ensuring that staff, sub contractors and delivery partners adhere to all applicable local and national prescribing guidelines, policies and commissioning statements. Prescribing data will be available for scrutiny and assurance by the Commissioner.Providers will have a robust procurement process which ensures best value for money. The prescribing costs of medicines which the Provider is responsible for supplying will be fully attributable to the service provider. The service will not include a separate prescribing tariff.All prescribers will make sound prescribing decisions based on the individual patient circumstances, including and not limited to allergies, drug interactions, renal function and hepatic function.Where there is a requirement for the Provider to levy a prescription charge this will be undertaken.All patients or their carers will be involved in decisions about their ongoing pharmaceutical service e.g. patients will be able to use their community pharmacy of choice for ongoing supplies; patients will be involved in decisions about Dispensing Appliance Contractors. Patients attending clinics should receive a prescription or supply from the provider for a minimum of 28 days for any new medication that is requested.Information should reach the GP at least 10 working days before the treatment runs out and should include the minimum data set of core content of records for medicines when patients transfer care providers. |
| **6.0 Interdependencies** |
| 6.1 | Links to other teams in same organisation/ secondary care/ primary care |
| There are clear interdependencies between the adult community services model being procured, and a range of providers and services that the Provider will need to work with in order to develop its approach to delivering the service requirements. The Provider will support effective flow across the health and social care system and reduce the number of non-elective admissions into an acute hospital which could be more appropriately managed within a community setting. The Provider will be required to work collaboratively with a wide range of stakeholders, including secondary care, NHS 111, ambulance service, patient transport service, local urgent care services and other professionals and health care agencies. They will have to demonstrate effective pathways and optimise positive outcomes for patients, working across the following service providers, including but not limited to:**6.1.1 Secondary Care Services** 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 ensure contractual arrangements are in place 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 (including but not limited to): COPD, cardiology, diabetes. By working proactively with secondary care, the Provider will help to build seamless provision of care for patients and reduce any overlap of duplication of services. The Provider will be expected to make better use of technology i.e. use of teleconsulting to help provide access to specialist advice and support in secondary care. **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.The Provider must comply with SHREWD requirements to support the wider health and social care economy.**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 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 works 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**The Provider will ensure that mental health and wellbeing is integral to the care delivery in Medway. It is imperative that the Provider responds to the mental health needs of patients ensuring that there are no inequalities in the delivery of care. It is essential that people living with mental health problems receive the right help at the right time and is in line with evidence based care. The Provider will ensure that staff are aware of mental health pathways and services in Medway, to enable referral and appropriate signposting. The Provider will work with mental health services, GP practices, social care and the voluntary sector (where appropriate) to ensure that people in their services, who have mental health needs are identified and then supported appropriately. The Provider will ensure that staff work with mental health services to ensure robust processes for communication and information sharing are in place.**6.1.7 Stroke Services**Community stroke services are out of scope of of this specification and the Provider responsible for delivering the new 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 these professionals ) 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 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
* 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.
 |
| **7.0** | **Digital, Information, Communication and Technology Requirements** |
| 7.1 | Interoperability, remote treatment services, digital governance and culture, patient services |
| The provider is required to: * Meet **Interoperability** requirements as per the appendix - support safe and effective healthcare by the Provider, working in conjunction with patients and other providers across the local health economy, providing the following capabilities: inter-operability with other providers and patient facing services.
* Meet **Remote Treatment** requirements as per the appendix - The Provider will be experienced in delivering a range of remote treatment options to support the urgent response function and day to day patient care including: telehealth, telecare, web portals and smart phone Apps; as well as and the delivery of care over SMS messaging, and phone support for patients with low digital literacy.
* Meet **Digital Governance and Culture** requirements as per the appendix - the Commissioner is looking to work with a Provider with a mature digital culture involving patients and clinicians, which is forward thinking and achieving national and international recognition.
* Meet **Patient Services – Portals, engagement and specific support** requirements as per the appendix - the Provider should support patients by offering online interactive services as part of the range of services offered, including: a basic booking service i.e. automation of clinic booking, rescheduling and reminder system. Systems should support patients to be able to choose how they receive confirmations and reminders online, by text message, or email. In addition, they will be able to change appointments, receive patient letters and access care plans
* Meet **Generic ICT Best Practice Requirements**  as per the appendix
 |
| **8.0** | **Facilities and ICT** |
| 8.1 | Location requirements |
| The provider will, in line with the Medway Model provide 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. The Provider must seek prior approval from Commissioners to change the location of service provision.  |
| 8.2 | 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. |
| **9.0** | **Workforce** |
| 9.1 | Building a workforce for the future |
| 9.1.1 Across the whole system, in line with the KMSTP Local Care agenda, the workforce will progressively be deployed differently to support the realignment of resources from the hospital into primary and community services. The Provider will continue to work with the Commissioner and the wider system to meet the changes and challenges ahead. This will include: contributing to the development of strategies to help attract and recruit as well as retain professionally qualified nursing and other health professionals to the local area. The Provider will contribute to the partnership development of “growing our own” health and care staff, work with training and education establishments and support workforce initiatives; including wider STP work and contributing to local primary and secondary care workforce strategies.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. The Provider will be responsible for ensuring resources are utilised in the most efficient way whilst ensuring that systems are in place to ensure integrated delivery of care and interventions. The Provider must ensure the right people, with the right skills, are in the right place at the right time and the Provider must ensure sufficient staffing capacity and capability is made available to meet the needs of the local population, taking into account population growth and increased demand. The Provider will flag any gaps in staff training or qualifications and develop action plans to demonstrate how the gaps will be addressed. |
| 9.2 | Staff competency requirements |
| 9.2.1 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 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 and specialist staff. 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. MECC training) and are able to have conversations with patients about making healthy behaviour changes and signpost to services for further support. |
| 9.3 | Safe staffing levels |
| 10.3.1 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. |
| 9.4 | Ongoing training and development |
| 9.4.1 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 staff, by the specialist 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.The Provider must make best use of professional skills and provide career pathways for all staff. The Provider will work with other partner organisations to develop clear career pathways that promote integrated working. The core focus of all staff will be to work effectively across organisational boundaries with a “One Team” approach working flexibly to prevent, reduce and delay the needs of patients/carers and take a holistic approach to the provision of health and care support. The Provider must ensure that all staff are appropriately skilled, experienced, registered (where necessary and appropriate) and competent to occupy their designated roles in line with the guidelines of their professional bodies (for example, the Royal College of Nursing, Royal Chartered Society of Physiotherapists). |

|  |  |
| --- | --- |
| **10.0** | **Business Continuity and Resilience** |
| 10.1 | Continuity and resilience |
| In addition to any other requirements within the Contract, the Provider shall maintain an up to date and tested emergency preparedness response plan which: * Describes the approach to business continuity and service resilience, including their underpinning governance, infrastructure, ICT, Estates and workforce arrangements
* Documents in detail the arrangements they will make to ensure service continuity and resilience from the Services Commencement Date and throughout the life of the Contract
* Explains how they intend to participate in local emergency planning and response arrangements
 |

|  |  |
| --- | --- |
| **11.0**  | **Sustainability** |
| 11.1 | Sustainability |
| In addition to any other requirements within the Contract, the Provider must manage its services to deliver wider social benefits by taking reasonable steps to minimise its adverse impact on the environment and maximise the economic and social opportunities, and report their actions to commissioners, to support commissioners to comply with the Public Services (Social Value) Act 2012. |

|  |  |
| --- | --- |
| **12.0** | **Mobilisation Requirements** |
| 12.1 | Mobilisation requirements |
| For the avoidance of doubt the following requirements in this section are in addition to any other requirements within the Contract (and where there is any inconsistency the more onerous requirements will apply). The Provider must mobilise services and be ready to operate services from the relevant agreed Service Commencement Date.**12.1.1 Mobilisation Planning and Control** The Provider must (and these will also be captured in the Contract e.g. in transition arrangements under the Contract):• Provide a robust project and resource plan for mobilisation, which identifies the approach to mobilisation, the critical milestones and any resources required, including commissioner resources and those from the incumbent service provider(s). NO charges, fees or other costs will be payable to the Provider by the CCG for the provision of the Mobilisation of Services (including where additional Mobilisation Services are required during the mobilisation phase * Jointly agree a staff engagement plan to ensure all current clinical staff are updated on changes in a planned way. Engagement plan to be signed of between Commissioner and new provider.

• Ensure the necessary personnel attend the Mobilisation Governance Structure meetings as set out by the CCG• Fully co-operate with the CCG and the Former Supplier in respect of Mobilisation during the Mobilisation Phase• Identify significant risks, dependencies and constraints, such as the need for a transfer under TUPE, the need to be permitted to join the NHS pension scheme, the need for CQC registrations, access and licences for premises or ICT or any risks due to the number or qualifications of staff needed for the Services. Selected Bidders must explain how risks, dependencies and constraints will be communicated and managed or mitigated • Provide appropriate leadership, governance, control, assurance and reporting for their mobilisation project, including moving from mobilisation to the business as usual governance for the Contract• Ensure that any subcontractor mobilisation will be governed and managed within their overall project.**12.1.2 Mobilisation - Staffing and Workforce** The Provider must (and these will also be captured in the Contract e.g. in transition arrangements under the Contract)• Take appropriate advice and be able to demonstrate on contract award that that advice has been taken on the legal basis for staff transfers• Demonstrate that they will affect transfers in accordance with Schedule 9.0 of the Contract• Communicate and consult with staff and managers and staff representatives for those who may be affected as part of the mobilisation to the new service • Maintain a safe and well led services during mobilisation and beyond• Maintain safe staffing levels and work with existing providers and partner organisations to ensure that there are sufficient, appropriate skilled and qualified staff during mobilisation and from the service commencement date, both in the services and in the mobilisation project team • Work with existing employers where there is a TUPE transfer, so that risks to safe delivery of Services are identified and mitigated• Undertake induction, training and development activities for all staff transferring under TUPE or starting newly with the Services; • Ensure that any new staff or contractors have appropriate screening or pre-employment checks before participating in the mobilisation project or service delivery• Undertake due diligence activities on any transferring staff, contractors or agency workers.**12.1.3 Mobilisation - Estates and Infrastructure** The Provider must:• Ensure that they have continued access to premises and IT to be able to deliver the Services from the Service Commencement Date and thereafter; • Have the Information Management & Technology systems, services, hardware, software, infrastructure and security arrangements in place to deliver and report on Services from the Service Commencement Date; and • Provide the Services from the Service Commencement Date using the estates mandated in the Contract (add relevant section). Where estates and facilities for non-clinical or administrative functions are required the Provider will ensure that they will deliver services from safe, secure and appropriate buildings. **12.1.4 Mobilisation - Stakeholders, Patients and Carers** The Provider must: * Communicate with stakeholders, service users, patients and carers in the period before and after the service commencement date, to ensure that they are informed about any changes to services.

**12.1.5 Mobilisation - Business Continuity, Resilience and Risk** The Provider must:• Have appropriate business continuity and resilience arrangements in place from the service commencement date • Have appropriate risk management systems in place for the service commencement date. **12.1.6 Mobilisation - Legal and Commercial** The Provider must:• Ensure that any sub-contractor agreements, alliance agreements or integration agreements are signed and in place for the service commencement date• Understand the nature of contracts for staff, services, infrastructure and estates, and have arrangements in place to continue those contracts at service commencement date or to replace them before the service commencement date, so that service delivery is not adversely affected.   |