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| **Service** | Adult Community Services |
| Specification Reference | Specialist Support Functions (Part 3) |
| Period |  |
| Last Updated |  |
| Service Value |  |

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| **1** | **Introduction and Context** |
| 1.1 | Summary/ Introduction |
| This specification sets out the requirements of the Provider in relation to the specialist support functions to be provided as part of the Adult Community Services. This document should be read in conjunction with the Generic (Part 1) and the Core service specification (Part 2). 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 |
| **Please see Generic Service Specification** |
| 1.3 | National and local trends |
| **Please see Generic Service Specification** |
| **2** | **Service Description**  |
| 2.1 | Description (including summary of overarching aims) |
| The Provider will ensure that the specialist support function will provide responsive access to specialist advice and interventions to support the core generalist staff in the community. These specialist clinical staff will work across Community Locality Teams (CLTs) taking a leadership role in educating core generalist staff. The provider will make available training and education to, but not limited to: Primary Care, Voluntary Organisations and other professionals outside the scope of this procurement, as well as providing direct advice, training and education in the most complex of cases. The Provider will ensure that these staff have advanced clinical and therapeutic skills and can offer expertise and guidance when required, and are also able to provide direct clinical care and intervention in clinically complex cases requiring specialist input. The specialist support function includes, but is not limited to: * Cardiology

• Continence and stoma care• Dementia• Diabetes education service• Epilepsy• Learning disability • Lymphoedema• Nutrition and dietetics• Podiatry• Respiratory• Specialist palliative care• Speech and language therapy* Tissue viability and wounds

The Provider will ensure the specialist support function establish formal links with secondary care specialist teams to ensure the maintenance and continuous development of specialist skills including (but not limited to) clinical support and supervision, governance and infrastructure. The Provider will ensure the specialist support function will establish robust links with primary and community professionals including (but not limited to) Community Locality Teams (CLTs), social care teams, General Practice, mental health teams to ensure access to a diverse range of specialist staff.**2.1.1 Aims and Objectives**The specialist support functions will provide seamless support to the CLTs and primary care and will help to achieve:* A reduction of emergency admissions and attendances at A&E 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.
	+ Improved access to a full range of specialist staff; that offers a responsive service in accordance with the clinical needs of patients.
	+ An upskilling of primary care professionals and community professionals in the specialist management of long term conditions.
* An integrated approach to working with secondary care specialist services to deliver comprehensive support in the community.
* A high quality experience of care for patients, their families and carers.
	+ A reduction in the need for long term care through effective preventative care and promotion of self-management.
	+ The effective and efficient management of resources to deliver an excellent standard of service within the financial envelope available.
	+ A revised model of care and service delivery, utilising evolving best practice.
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| **3** | **Specialist Support Function** |
| 3.1 | Functions |
| The specialist support function is a fundamental element of the Medway adult community services model. They will provide:* Expert clinical input and advice to each CLT.
* Expert clinical input and advice to primary care.
* Education, training and competency development to upskill community and primary care staff.
* Excellent care targeted at patients requiring expert and specialist intervention.

The clinical inputs and interventions provided by the specialist support functions are described in detail within subsequent sections of this specification, however in broad terms, it will deliver the following key operational functions:* Advanced assessment, care planning and co-ordination of complex patients.
* Provision of advanced clinical advice and support to the core generalist functions within the Community Locality Teams (CLTs). The Provider will ensure that the specialist support function works across locality teams taking a leadership role in providing direct advice, education and care in the most complex of cases.
* Integration with primary care. The specialist service function will develop strong working relationships at an operational level with professionals in primary care. This will include representation of key staff at Integrated Locality Review (ILRs) and the alignment of named staff to practices or clusters of practices.
* Facilitating access to other professionals. The effectiveness of the specialist service function will not only be determined by how well it delivers direct advanced clinical care but also how well it interacts with other professionals to ensure care is co-ordinated, to ensure seamless collaborative working between other professionals (as listed below).
* Integration with secondary care. The specialist service function will work closely with secondary care to ensure continuous development and ongoing training; ensuring the most up to date, clinically evidenced based practice is applied.
* Integration with social care. The specialist support function will develop more integrated working between the community and social care. The Provider will ensure that integrated relationships with local social care teams are developed and aligned with the CLTs, to deliver holistic care and facilitate seamless support, advice and signposting.
* Integration with the voluntary sector. The specialist support function will be pivotal to the involvement of the voluntary and third sector to ensure that patients receive support when required i.e. promoting well-being and helping patients to stay healthy for as long as possible. By directing patients to the right support i.e. care navigation; this can help patients to manage social isolation and any other issues that are impacting on their health.
* Integration with public health / health promotion services. The specialist support function will develop integrated working between community services and public health/health promotion services, to promote conversations about prevention and healthy lifestyle behaviours at every point of care. Where appropriate this will be aligned with the CLTs, to deliver holistic care and facilitate seamless support, advice and signposting.
* Leadership of Advance Care Planning and End of Life Care. The specialist service function will have a fundamental role in improving the quality and frequency of advance care planning. The Provider will ensure that people approaching end of life or potentially within the last year of life are identified and effectively managed including the development of advanced care plans and promotion of the My Wishes registry.
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| 3.2 | Clinical and Therapeutic Interventions  |
| All specialist clinical support functions will share two key work streams:**Clinical Expertise** The Provider will ensure that the specialist support functions will be sought when the management of complex patients falls outside of the remit of the core generalist’s knowledge and skills. The Provider will foster joint working between the specialists and the core generalists within the CLTs, so both functions are clear of their remit. The specialist support functions will only manage a very small active caseload, which will be determined by the complexity level and the need of highly specialist clinical input. In addition to the above, each of the specialist support functions listed below, will be responsible for undertaking generic duties in relation to clinical expertise that will apply across all functions:* Capturing all specialist interventions in the patient’s Integrated Management Plan (IMP)
* Providing expert clinical advice and support to core generalists and other professionals either directly or remotely.
* Attend Integrated Locality Reviews (ILRs) where necessary to provide specialist advice or present patients for review.
* Undertake training to ensure competencies for prescribing and treatment initiation can be met when necessary, to support early intervention and provision of specialist prescribing advice to CLTs or ILRs.

**Clinical Education and Support** The Provider will ensure that all of the specialist support functions develop robust training and support programmes to improve patient outcomes through training, education and staff development. The specialist support functions will proactively evaluate outcomes and conduct training needs analyses to identify opportunities to improve the competencies and capabilities of core generalist staff, to help reduce variability in the quality of care. The Provider will proactively engage with organisations and providers outside this specification (but not limited to) primary care, public health / health improvement services, care homes, hospices, social care, mental health teams and any other service where there is a clear opportunity to improve patient outcomes and ensure efficient practice.For some specialist support functions i.e. respiratory, cardiac, continence, diabetes and tissue viability, the Provider will ensure training plans, education sessions and exercise groups are organised, co-ordinated and supervised by the specialist support functions, but where appropriate the delivery can be delegated to the core generalists.In addition to the above, each of the specialist support functions listed below, will be responsible for undertaking the following generic duties in relation to clinical education and support, that will apply across all functions:* Assurance in relation to clinical governance and clinical audit
* Management of direct referral pathways to secondary care
* Access to and awareness of clinical treatment trials and research/ evidence based practice updates
* Active participation in continuous professional development to ensure staff update skills and practice in line with current guidelines
* Regular review of NICE guidance including the updating of all Provider policies and training packages to reflect new guidance
* Ensuring staff are trained as independent prescribers
* Provision of education and support to the CLTs and primary care staff

**3.3.1. Diabetes**Clinical Assessment/Review:This includes the clinical assessment and review of the population at risk of diabetes. The Provider will be required to work in close collaboration with Public Health and primary care regarding the implementation of campaigns to promote healthy lifestyles and wellbeing to help reduce the incidence of early onset diabetes.The diabetic specialist functions will lead the initiation of insulin in the community. **3.3.2. Tissue Viability and Wounds**Clinical Assessment/Review:The Provider will offer assessment and treatment for patients with highly complex wounds and skin conditions including specialist procedures such as, but not limited to: sharp debridement, skin biopsy, and topical negative pressure. The Provider will work with the Medway Integrated Community Equipment Service to advice on pressure relieving equipment.**3.3.4 Respiratory**Clinical Assessment /Review:The specialist support function will provide highly skilled support to patients that are tailored to meet their individual needs in a variety of respiratory conditions i.e. Chronic Obstructive Pulmonary Disease, Bronchiectasis, Emphysema, Cystic Fibrosis and interstitial lung disease. They will also provide support to the core generalists in the provision of a home oxygen service.**3.3.5. Nutrition and Dietetics**Clinical Assessment/Review:Some dietitians within the specialist support function will have areas of further expertise within specialist areas i.e. including but not limited to: Oncology, diabetes, paediatrics, respiratory, intensive care, nutrition support (enteral and parenteral feeding).**3.3.6. Continence** Clinical Assessment/Review:The Provider will deliver comprehensive, evidence based continence promotion and treatment support based on individualised assessments to treat and manage complex bladder and bowel dysfunction. The service will provide and support diagnostics including bladder scanning, urinalysis, observation of the perineum, digital vaginal examination to assess and teach pelvic muscle exercises, digital rectal examination to assess and treat male pelvic muscle exercises and to exclude faecal impaction if necessary, the service will create plans for bladder retraining, fluid advice, toileting regimes and advice on bowel care. **3.3.7. Dementia**Clinical Assessment/Review:The Provider will ensure that specialist support functions put in place help to prevent or minimise the inappropriate use of anti-psychotic medication, including advice on alternative strategies. Specialist assessment of complex cases will support core teams to treat patients at home, anticipate crisis and help reduce anxiety and depression. Specialist support input will be pivotal during crisis intervention and patients with challenging behaviours. **3.3.8. Epilepsy**Clinical Assessment/Review:The Provider will ensure the specialist support function delivers nurse-led clinics, offering medication reviews and working alongside primary care to support and control seizure triggers. **3.3.9. Lymphoedema**Clinical Assessment/Review:The service will provide high quality care and specialist advice that is subject to well-defined and comprehensive protocols and pathways relating to ongoing assessment, planning, education, advice, treatment and monitoring of lymphoedema. The Provider will offer treatment options, not limited to, Kinesio taping, Decongestive Lymphatic Therapy in form of Manual Lymphatic Drainage, Multi-Layer Lymphedema Bandaging, Intermittent Pneumatic Therapy, Deep Oscillation Therapy and Lower Light Laser Therapy are assessed and tailored for individual patients. Through their specialist support to the core team the provider will reduce the complications of lymphoedema and chronic oedema such as cellulitis, secondary skin changes, disability and lymphorrhoea (leaking legs). The Provider will determine the correct garments and ensure these are correctly fitted to support ongoing treatment. **3.3.10. Cardiology** Clinical Assessment/Review:The Provider will ensure the specialist support function comprises, but is not limited to, the following elements: * Cardiology
* Cardiac Rehabilitation
* Heart Failure (LVSD)
* Diagnostics
* Arrhythmia
* Syncope
* Palpitations
* Anticoagulation

The specialist support function will deliver specialist support to the CLTs in the management and treatment of heart failure patients. The Provider will ensure staff work closely with secondary care professionals to develop collaborative working practices and pathways between secondary care, primary and community care.The Provider will ensure close working with primary and secondary care in the diagnostic and management of arrhythmias and unexplained syncope and palpitations. The Provider will ensure relevant information i.e. referral pathway algorithms are made available to GPs along with educational support. The Provider will also ensure that the specialist support function ensures that staff are appropriately trained in ECG analysis to ensure accurate diagnosis of arrhythmia and atrial fibrillation conditions.**3.3.11. Podiatry**Clinical Assessment/Review:The Provider will provide specialist support functions for the treatment of ulceration and complex foot problems. The Provider will ensure that patients with complex foot problems have clinical interventions delivered by advanced specialist podiatrist e.g. diabetic podiatrists, and will prioritise the treatment and regular follow-up of problems associated with the diabetic foot as well as rheumatology and vascular conditions that pose a high risk to foot health.**3.3.12. Speech and Language Therapy**Clinical Assessment/Review:The Provider will ensure that specialist support functions for speech and language therapy enable patients to maximise their communication / swallowing ability, particularly in relation to (but not exclusive) of the following conditions: aphasia, dyspraxia, dysarthria, dysphonia, dysfluency and dysphagia. Examples of support provided by the specialist nurses and therapists include, (but are not limited to):* Differential diagnosis, rehabilitation and management of communication disorders as a result of brain injury and progressive neurological conditions.
* Assessment, rehabilitation and management of swallowing disorders, including for those with advanced dementia or other neurological impairment.
	+ Voice therapy for neurological diseases.
	+ Assessment for, and provision of, patient-tailored low tech communication aids.

• Differential diagnosis of swallowing difficulties in relation to adults presenting with a dual medical diagnosis of both an acquired neurological condition and dementia.• Differential diagnosis of swallowing difficulties in adults presenting with either an undiagnosed neurological condition or other medical conditions e.g. oesophageal presentation• Onward referral as appropriate to specialist centres for assessment of high tech communication aids.* + Internal training on a range of specialist topics e.g. to members of the Integrated Locality Team and wider primary care and health care professionals

**3.3.13.Learning disabilities**Clinical Assessment/Review:The specialist support staff will support people with learning disabilities and their families to experience improved health and social outcomes through supporting patients with health issues they would not be able to manage independently, including annual health checks, screening services and medication reviews.**3.3.14 Specialist Palliative Care:**Clinical Assessment/Review:The Provider will ensure that specialist palliative care will be delivered across settings (i.e. acute, hospice and community) where there is an identified need. This will help to facilitate patients preferred place of care and to support the wider workforce in ensuring unnecessary hospital admissions are avoided. The Provider will ensure that those working in specialist palliative care, have the required specialist qualifications, skills and experience to provide clinical leadership and deliver care to people, their carers and those important to them. The Provider will ensure that staff provide clinical support, advice and education to other professionals to deliver core level palliative and end of life care. The main components of specialist level palliative care include, but are not limited to:• In depth specialist knowledge to undertake assessment and management of physical, psychological and spiritual symptoms to reduce symptoms, suffering and distress;• Supporting analysis of complex clinical decisions-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment;• Providing care and support to those important to the person receiving care, including facilitating bereavement care.A specialist level palliative care is usually provided in three main ways:• Specialist level palliative care liaison work to support the person's care by their usual caring team• Specialist level in-patient palliative care• Specialist level out-patient services including group activities and therapeutic programmesThe Provider will ensure that the specialist palliative care function plays a lead role in developing and delivering best practice in palliative and end of life care and contributing to the delivery of education, training and continuing professional development to the wider workforce. The Provider will ensure staff at all levels lead on the development and implementation of new, innovative ways of delivering care for palliative/end of life patients and play an integral part of implementing a local end of life strategy. |
| **4** | **Service standards and best practice** |
| 4.1 | Standards, guidelines, links to professional bodies and benchmarking |
| **Please see Generic Service Specification** |
| **5** | **Scope and accessibility** |
| 5.1 | Inclusions and exclusions (geographical/ GP register restrictions, age, conditions/ thresholds) |
| **Please see Generic Service Specification** |
| **6** | **Interdependencies** |
| 6.1 | Links to the wider system |
| **Please see Generic Service Specification** |
| 6.2 | Shared care protocols |
| **Please see Generic Service Specification** |
| **7** | **Prescribing and medicines** |
| 7.1 | Prescribing protocol |
| The Provider will be expected to adhere to the Medway Prescribing Formulary. |
| **8** | **Workforce** |
| 8.1 | Staff competency requirements |
| **Please see Generic Service Specification** |
| 8.2 | Staffing levels |
| **Please see Generic Service Specification** |
| **9** | **Facilities, equipment and ICT** |
| 9.1 | Location requirements |
| **Please see Generic Service Specification** |