Service Specification

Service	Community Neighourhood Teams
Commissioner Lead	Wolverhampton CCG
Provider Lead	Royal Wolverhampton Hospitals NHS Trust
Period	1st April 2016 – 31st March 2017
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Background

The NHS and Social care are faced with the major challenges of using resources more efficiently and of meeting the needs of an ageing population in which chronic medical conditions are increasingly prevalent. The key task therefore is to implement a new model of care in which clinicians and Social Care professionals work together more closely to meet the needs of patients and to co-ordinate services. This model of integrated care would focus much more on preventing ill health, supporting self-care, enhancing primary care, providing care in people's homes and the community, and increasing co-ordination between primary care teams and specialists and between health and social care.

The Keogh review of Urgent and emergency care services in England published in 2013[1] recognised that the current system is under intense, growing and unsustainable pressure that is driven by demand from an ageing population.

He advocated a system wide transformation was the only way to find a sustainable solution.

Highlighting opportunities to 'move care closer to home', Dr Keogh states that 40% of A&E patients are discharged requiring no treatment, up to one million emergency admissions were avoidable in the previous year and up to 50% of 999 calls could be managed on scene.

In the updated report published in 2014, Dr Keith Willetts, Director for acute episodes of care NHS England, stated that "*we must not be fooled into thinking change isn't necessary. The pressures we highlighted last November still exist, and the challenges that the health and social care system faces in delivering urgent and emergency care remain*"[2]

In this report update, Dr Caron Morton, Accountable Officer, states that nationally there is a recognition that 'one size doesn't fit all' to a solution to this problem and that CCGs need to be supported and encouraged to develop local bespoke solutions for their populations.

In order to move from the current to the future system the report update proposes five key elements of change. These should apply to all patients, regardless of their age, location, co-morbidities or physical and mental health needs:

- Providing better support for people to self-care

---

[1] The Keogh Report on Urgent and emergency services – 1st stage report. Nov 2013
[2] Transforming urgent and emergency care services in England Update on the Urgent and Emergency Care Review. 2014

- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- Connecting urgent and emergency care services so the overall systems becomes more than just the sum of its parts

The NHS Confederation report 'Ripping off the sticking plaster'[3] advised that the NHS needs to find practical whole-system solutions to address current pressures and that failure to find such solutions, and to act on them quickly, could have dire consequences for patients, and for the NHS as a whole.

The report recognizes that the sheer scale of the challenge means that it cannot be tackled by NHS organisation's working in isolation. Solutions hinge on change happening across the system, and leadership and shared responsibility that unites all parts of the service.

To this end, a whole-system approach that involves all commissioners and providers of hospital, ambulance, primary, community, mental health and social care services working effectively together is required.

Local Context

Wolverhampton is one of the most densely populated local authority areas in England with a population of approx. 262,000 (registered population). The average age of residents in Wolverhampton is 39 similar to the national average; however broken down by specific age groups Wolverhampton has a slighter higher proportion of children aged less than 16. The older population is predicted to increase over the next 10 years in line with the national average.

Population forecasting undertaken indicates that the number of males and, to a lesser extent females aged 85 and over is to increase significantly by 2018. The Wolverhampton Joint Strategic Needs Analysis (JSNA) supports this with population projections showing increases across both 65 to 84 and 85 and over age groups for males and females.

The CCG has developed operating plans that cover two and five year periods and detail that strategic objectives and priorities.

This service will contribute to three of these objectives:

Strategic Objective	
Transferring and integrating services to maximise the quality of care	✓
Development of services and capacity outside of hospital	✓
Assurance, monitoring and development ensure quality and access to services	✓

The shift to the implementation of multi disciplinary, integrated Community Neighbourhood teams will realise a move from commissioning episodic care to a more outcomes based approach focussing on patient holistic needs.

Community Neighbourhood Teams

The development of Community neighbourhood teams is part of a large programme of work

[3] Ripping off the sticking plaster Whole-system solutions for urgent and emergency care

being delivered under the umbrella of the Better Care Fund. The Better Care Fund, consists of all health and social care organisations in Wolverhampton who have agreed to work better together to commission and provide safe, high quality and financially sustainable services for the residents of Wolverhampton.

By adopting a more integrated approach the aim is to prevent people having unnecessary stays in hospital, reduce demand on emergency and urgent care services, and improve health and social care outcomes for everyone in Wolverhampton.

The delivery of Community Neighbourhood Teams is underpinned by the following underlying principles:

- Services should be safe, accessible, convenient and responsive
- Patients should receive high quality care person centred care
- Health and Social professionals see a shift from delivering episodic care to a more integrated, person centred model of care
- Patients should be empowered and supported to manage their own care and self-care where clinically appropriate.
- Services should be local wherever possible
- Services should be centralised where necessary (to ensure clinical safety).
- Care should be seamless across health and social care. Patients shouldn't be impacted by silo working
- Information and communications should be centred on the needs of the patient not the organisation or professional taking into account the diverse population of Wolverhampton

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.1.1 Adult Social Care Outcomes Framework

Domain 1	Enhancing quality of life for people with care and support needs	✓
Domain 2	Delaying and reducing the need for care and support	✓
Domain 3	Ensuring that people have a positive experience of care and support	✓
Domain 4	Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	✓

2.1.2 Public Health Outcomes Framework

Outcome 1	Increased healthy life expectancy	✓
Outcome 2	Reduced differences in life expectancy and healthy life expectancy between communities	✓

2.2 Locally defined deliverables

- A progressive increase in Improved customer experience, satisfaction
- A progressive increase in a real shift of appropriate activity into appropriate services within the Community neighbourhood team
- Improved partnership / shared care working with Primary Care
- Improved access to services that are able to swiftly support early discharge from hospital
- Access to flexible services that are able to swiftly react to emergency situations that include exacerbation of chronic conditions
- Improved access to flexible services that support the holistic needs of patients through delivering seamless care at the appropriate time, place and delivered by the most appropriate professional(s)
- A progressive reduction in A&E attendances and emergency admissions
- Improved clinical outcomes for patients through the implementation of seamless, risk managed, safe pathways of care
- Reduced duplication of assessment (health only)
- Appropriate sharing of information between professionals and organisations enabling effective joined up care
- Delivery of efficient and effective services based on the holistic needs of the identified patient population
- Improved health and social quality of life for patients with LTC's or life limiting conditions
- Adopt a preventative and proactive approach to the delivery of services focusing on supporting patients with the knowledge and skills to facilitate self-care, improve general wellbeing and promote independence
- Patients identified as at risk or with increased risk score identified and proactively case managed with appropriate and timely interventions to maintain their care within a community based setting.
- The delivery of care co-ordination for all patients with a nominated lead professional for their care
- An effective risk management approach to delivery of care closer to home and enabling patients to self- manage their condition within their usual place of residence
- Evidence of learning from untoward incidents and action planning being core to the operational delivery of the services

3. Scope

3.1

Service Description

Each Neighborhood Team will wrap around a number of GP practices and their populations. The teams will be made up of district nurses, community matrons, intermediate care professionals and social workers along with the existing GP practice staff.
People who use services, along with their family and carers, will be at the heart of these teams.

Linking in with the neighborhood teams will be a whole range of specialist and other services, including services provided by the voluntary sector for example :

- Age UK

The teams will provide a service in a variety of settings, primarily the persons own home but delivering some interventions in other locations such as GP practices, community clinic locations or residential/care homes.

The skill mix and capacity of the teams within the localities will vary to meet the particular health needs of each locality and allow maximum flexibility in resource allocation.

As a minimum, the team will consist of:

- Advanced Nurse Practitioner
- Community Matron
- District Nurses
- Therapists
- Social Care professionals

3.2 Aims of the service

The aim of the Community Neighborhood teams is to provide multidisciplinary, seamless care closer to a patient's home, reducing admission to hospital and facilitating speedier and timely discharge.

70 per cent of premature deaths are caused by detrimental health behaviors, it is vital that people engage more with improving their own health.[4]

What people do in their everyday lives – what they eat, how much they exercise and how far they follow medical advice – largely determines their health and their need for health care (World Health Organization 2005).

The Community Neighborhood Teams will deliver a wide range of interventions including working with patients to achieve better self-management of their long term conditions. It will incorporate clinical intervention when needed however it is also about working with and supporting patients to develop a personalized approach to their conditions

One of the aims of the Community Neighborhood teams is to increase 'Patient Activation'.
The influence of patient behavior on health outcomes can be seen in everything from preventing illness in the first place through to the management of long term health conditions.

Patient activation refers to a person's ability and willingness to take on the role of self-management of their health and health care needs. The higher the level of activation the higher the patient's engagement in healthy behaviors, self-management and knowledge regarding their conditions.[5]

Activation focuses on embedding the skills and knowledge required for day-to-day management of health. The service will aim to increase patient's engagement with their own health it will support patients to manage their conditions reducing the need for avoidable admission to hospital and reducing dependency on community health services.

The Community Neighborhood team will include Community Matrons, Advanced Nurse Specialist, District Nurses, Occupational and Physiotherapists, calling on support where needed from other professionals.

3.3 Service Objectives

- Increased patient satisfaction with clinical and social care services
- Reduce the fragmentation of care provision so that there is seamless, integrated

[4] Supporting people to manage their health. The Kings Fund May 2014
[5] Supporting people to manage their health. The Kings Fund May 2014

and personalised care, when and where people need it, ensuring that patients do not get lost in a complex system

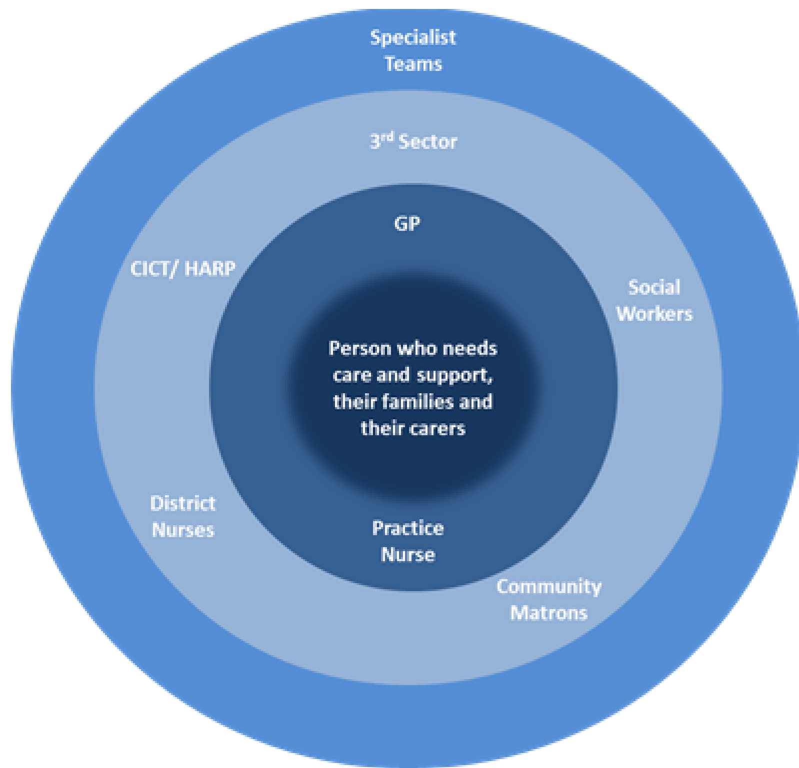
- Provision of services that encompass the whole patient journey, are fully integrated and centred on patients' needs
- The provision of integrated care , centred around the patient with access to local services, providing continuity of care;
- Provide a coordinated quality focussed service to receive referrals from health and social care professionals within the community
- Facilitate and co-ordinate the provision of holistic care required to support the patient (health and social care)
- Monitor the delivery of care to ensure that the agreed health and social input is received in a timely manner/to the timescales agreed
- Improve accessibility to community based services (health and social care)
- Less time spent by referrer navigating services in an urgent, intermediate or longer term situation
- Pathways to other support services will be jointly developed to facilitate smoother referral processes
- Communication between services (health and social care) will be appropriate to ensure timely treatment and/ or discharge from services
- Reduction in unnecessary admissions to hospital of patients who could be cared for at home, in crisis,
- Increase early discharge of patients from hospital who no longer require acute medical intervention
- Delivery of safe, robust clinical & social outcomes
- Delivery of seamless care with reduced duplication of assessment and diagnostics (health only)
- All professionals will facilitate and the sharing of necessary information to provide holistic, person centred care
- Community Neighbourhood Teams will be locality based and aligned around a number of GP practices and their populations
- All professionals will work in a collaborative manner delivering a shared care approach to the identified patient population
- Locality based teams will the development of the workforce to meet the changing health and social needs of the identified population

3.4 Service Model

The community neighborhood teams will have a single access point which will receive all referrals from health and social care professionals that meet the criteria of each team. Referrals will be directed to the most clinically appropriate service for the identified need of the patient.

The different functions of the Community Neighborhood Team include:

- Rapid Response (which will include Home In reach Team, service specification to be developed following end of pilot in March 2016)
- Intermediate Care (CICT)
- Community Delivery Team (Service Specification under review)
- Delivery of Core District Nursing Service (Service Specification under review)



Functions of Community Neighborhood Teams:

Risk stratification

Community matrons will work closely with GP practices to risk stratify and identify patients who have either complex needs or at risk of admission and would benefit from a case management approach or would benefit from multidisciplinary team discussion. Patients at risk of admission to hospital will be identified through the use of a risk stratification tool (Aristotle).

The purpose of this is to agree with the person a planned 'shared care' holistic person centred approach which stabilises the person's condition and prevents further unnecessary admissions and/or supports earlier discharge. Management of the patient will include designation of a case manager who will co-ordinate the provision of care. The case manager will be the most appropriate health or social care professional depending on the patient's assessed clinical or Social needs

Integrated Case Management

Community Matrons will proactively case manage patients referred by their GP for complex care needs.

Intermediate care (CICT)

Neighbourhood community teams will work with patients to achieve their optimum potential and maintain them in their own home or residence of choice. This service element will facilitate the delivery of all forms of intermediate care, providing an interface between primary and secondary care and working closely with the rapid response team.

The patients who are the focus of this care include those who:

- require further rehabilitation following an acute medical or surgical episode;
- require further rehabilitation following a fall, once their medical treatment is in place;
- Following an acute care episode, patients with long term conditions such as stroke, Multiple Sclerosis, Parkinsonism, head injuries, obstructive airways problems requiring additional support or rehabilitation.

In all cases each individual will be assessed and their care will be tailored to meet their individual needs.

Facilitated Discharge from acute care to intermediate care

The Neighborhood Community Teams will assist patients who are medically stable in an acute setting by providing a short term rehabilitation intervention designed to enable a timely, coordinated discharge from hospital.
The objective is to improve an individual's level of independence, help build confidence and to re-equip them with the skills to remain in their usual place of residence.
This approach is appropriate for people who are in hospital and can continue to regain their independence in the community (e.g fractured neck of femur).

Rapid Response

The aim of the Rapid Response function is to primarily prevent unnecessary hospital admissions by providing a multi-disciplinary team approach for those experiencing an acute episode of illness or injury that are in a health and social care crisis. The rapid response service utilises varying levels of interventions in order to prevent avoidable hospital admission and incorporates rapid response and assessment, crisis support and support/intervention during acute illness.
The service will provide care for a maximum of 2 weeks (exception by agreement based on clinical need).

Core District Nursing

Core District nursing provision will be delivered in line with current service specification

3.5 Care Pathways

The Community Neighborhood teams will be expected to utilise relevant care pathways to deliver integrated care including but not limited to:

- Rehabilitation and maintenance
- End of life care
- Urgent care services
- Falls
- Community beds (step up/step down)

3.6 Days/Hours of Function

- Rapid Response - 8am to 8pm, seven days a week (this will be a phased implementation following completion of a pilot)

- Intermediate Care (CICT & HARP) – 8am to 10pm, seven days a week

- District Nursing Service – Operational Monday to Sunday, 24 hours a day, 365 days a year including bank holidays)

- Integrated Case Management Team – will be provided from 8.30am to 5pm,

Monday to Friday, only exception is on Friday where core hours for social care team are 8.30am to 5.30pm with the intention to move to seven days a week

3.7 Referral Route

Health related referrals will be received via the locality single point of access.

Social Care referrals will be received via locality single point of access

3.8 Response time and prioritisation

- **Rapid Response** - The rapid response multi-disciplinary team see, assess, diagnose and treat the patient within two hours of referral to the service.
- **CICT** patients will be assessed and prioritized based on clinical need
- **Integrated Case Management Team** Referrals will be prioritized based on clinical need Outlined within Service Specification

3.9 Transfer of patent data

Providers must establish and maintain clearly documented responsibilities and procedures in relation to the transfer of patient identifiable and clinical information to services in line with current information governance standards.

3.10 Population Covered

The service is available to anyone aged 18 and over who is registered with a Wolverhampton CCG GP practice (health & social care), or, is resident within Wolverhampton and are registered with a non Wolverhampton CCG GP (social care only).

3.11 Accessibility/Acceptability

- The Community Neighborhood Teams will ensure that all individuals presenting with a health or social care need that can be appropriately & safely managed in the community are accepted for assessment and triage
- In addition case management, the team will focus on Long Term Conditions and Complex Case individuals selected by using a nomination criteria tool, secondary assessment and also a risk stratification tool

3.12 Referral Criteria and access

Referrals into the integrated care service will be accepted from the following professionals:-

- GPs
- Practice Nurses
- Consultants
- Specialist teams
- Secondary Care
- Patients (self-referral) only if previously known to the service via the message handling service within agreed protocols/timescales
- Social Care
- Social Care
- District nurses
- Community Matrons
- *Residential/Care Homes (referrals only accepted for rapid response service)

The provider will be responsible for the marketing and promotion of the service to the list of referrers as above

3.13 Whole System Relationships

The service will support effective, seamless patient flow across the health and social care system and reduce the number of non-elective admissions into an acute hospital which could be appropriately managed within a community setting.

The service will also support and enable timely discharge from an acute setting to a patients usual place of residence/step down beds where appropriate

3.14 Interdependencies

- Primary In Reach Teams (Residential Home support)
- Frail Elderly Pathway (In development)
- Dementia Pathway (In development)
- Any other service development applicable to this patient cohort

3.15 Service Development

All future service developments will be in line with delivering care closer to home and align with the CCG Strategic objectives.

4. Applicable Service Standards

4.1 Applicable national standards

- National Service Framework for older people DH 2001
- Intermediate Care – Halfway Home DH 2009[6]
- One chance to get it right The Leadership Alliance for the care of the dying person 2014[7]
- The six C's of delivering compassionate care[8]

4.2 Applicable standards set out in Guidance and/or issued by a competent body

- NHS Five year forward view[9]
- NHSE Using case finding and risk stratification: A key service component for personalised care and support planning[10]
- NHSE West Midlands 5 year plan[11]

4.3 Applicable local standards

[6] DoH July 2009
[7] Leadership Alliance for the care of the dying person – June 2014
[8] The Royal College of Nursing – Dec 2012
[9] NHS Five year forward view. NHSE October 2014
[10] Using case finding and risk stratification – NHSE January 2015
[11] NHS England West Midlands Five Year Plan on a Page - February 2015

5. Applicable quality requirements

5.1 Applicable Quality Requirements

These outcomes will require a baseline assessment prior to ongoing monitoring.

Outcome	Indicator
Patient Experience	Improve the experience of all patients in receipt of the specified services
	A reduction in the number of people experiencing delays in being transferred from hospital
	A reduction in the number of patients attending emergency care portals in an emergency
	An increase in the number of carers reporting that the care received was excellent
Patient Choice	All providers of care enable choice and promote preferred place of care at all times in line with their jointly developed care plan
	An increase in the number of patients who report being supported to remain in their usual place of residence if clinically appropriate
	An increase in the number of patients being offered a personal health budget and supported to access should they wish to
Treatment	All staff deliver optimal symptom control in line with the personalised care plan
	All patients report receiving advice, guidance and support on achieving optimal quality of life
Carers	All carers are made aware of and supported to undertake a carers assessment in line with National policy
Care Planning	There is evidence of person centred care being delivered at all times
	Systems and process are established across care givers to ensure effective and timely sharing of information and care plans
	All patients and carers(in line with the patients wishes) are involved in the development of a holistic care plan
	An increase in the number of people who state that they know who to contact in a time of crisis
	A reduction in the number of patients admitted to hospital as an emergency

	For patients who do not have capacity to express their wishes – carers report that the care received is in line with the care plan
Information & Education	Patients and carers (in line with the patients wishes) report that they are fully informed about the progression of the illness
	Patients and carers report that they are fully informed about what to do in the event of a crisis
	All information and communication is delivered taking full account of a patients individual needs

Reporting Requirements:

The following minimum data set will be required on a monthly basis :

Order	Name
1	Fiscal Year Month
2	Provider Code
3	Local Patient Identifier
4	Group Activity
5	Organisation Code (Local Patient Identifier)
6	Organisation Code (Residence Responsibility)
7	NHS Number
8	NHS Number Status Indicator Code
9	Age On Treatment
10	Lower Super Output Area
11	Person Gender Code Current
12	Ethnic Category
13	Language Code (Preferred)
14	Person Death Date
15	Death Location Type (Preferred)
16	Death Location Type (Actual)
17	General Medical Practice Code (Patient Registration)
18	Organisation Code (Code of Commissioner)
19	Service Request Identifier
20	Referral Request Received Date
21	Referral Request Received Time
22	NHS Service Agreement Line Number
23	Service Type Referred To (Community Care)
24	Source of Referral for Community
25	Referring Organisation Code

26	Referring Care Professional Staff Group (Community Care)
27	Priority Type Code
28	Primary Reason for Referral (Community Care)
29	Other Reason for Referral (Community Care)
30	Referral Closure Date (Community Care)
31	Referral Closure Reason (Community Care)
32	Discharge Date (Community Health Service)
33	Discharge Letter Issued Date (Community Care)
34	Community Care Contact Identifier
35	Care Contact Date
36	Care Contact Time
37	Administrative Category Code
38	Clinical Contact Duration of Care Contact
39	Care Contact Type (Community Care)
40	Care Contact Subject
41	Consultation Medium Used
42	Activity Location Type Code
43	Site Code (of Treatment)
44	Attended or Did Not Attend Code
45	Care Professional Staff Group (Community Care)
46	Earliest Reasonable Offer Date
47	Earliest Clinically Appropriate Date
48	Care Contact Cancellation Date
49	Care Contact Cancellation Reason
50	Replacement Appointment Booked Date (Community Care)
51	Replacement Appointment Date Offered (Community Care)
52	Community Care Activity Type Code
53	Group Therapy Indicator (Community Care)
54	Unique Booking Reference Number (Converted)
55	Patient Pathway Identifier
56	Organisation Code (Patient Pathway Identifier Issuer)
57	Waiting Time Measurement Type
58	Referral to Treatment Period Start Date
59	Referral to Treatment Period End Date
60	Referral to Treatment Period Status
61	Group Session Identifier (Community Care)
62	Group Session Date Time
63	Clinical Contact Duration of Group Session
64	Group Session Type Code (Community Care)
65	Number of Group Session Participants (Community Care)
66	Discharge Destination Code
67	Treatment Function Code

6. Location of Provider Premises

The Integrated Community Neighborhood Teams will be co-located in the following geographic localities:

- South West
- North East
- South East