NCL Community Services Strategic Review: Core offer report

September 2021

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Introduction and purpose of this report

Introduction

Before the formation of the NCL CCG, services were commissioned by each of the 5 legacy CCGs in isolation, leading to **substantial variation in the way services are commissioned and delivered across NCL**. This disparity is closely related to different levels of **historic funding** within the CCGs. The NCL Community Services Strategic Review seeks to create a **sustainable and affordable community model** across NCL that **addresses inequalities, spreads good practice** and **improves outcomes** for residents.

Community services would ideally be the **glue across our system** that help patients **stay well and support them to recover**. The review brings together **stakeholders from community services, primary care, acute care, social care and mental health services** to develop the interfaces and collaborative working across pathways. A **review of mental health services** is running in parallel, with integrated workstreams.

Purpose of this report

This report contains the **outputs from the development of the core offer for community health services.** The core offer was developed through an iterative engagement process through workshops, small working groups, one-to-one conversations and written feedback and input. The purpose of the report is to present the NCL-wide core offer for community health services across Children and Young People, Working-Age Adults and Older People. The core offer is intended to be **aspirational** and to reflect a **consistent** offer that **any resident of NCL can expect to access**, whichever borough they reside in. For each care function of the core offer, a specification is shown that aims to describe broad criteria for **delivery of a consistent and equitable offer across NCL.** Select pen portraits have been used to **highlight example pathways through the core offer.**

Aim, objectives and scope for the community and mental health services review

Aim

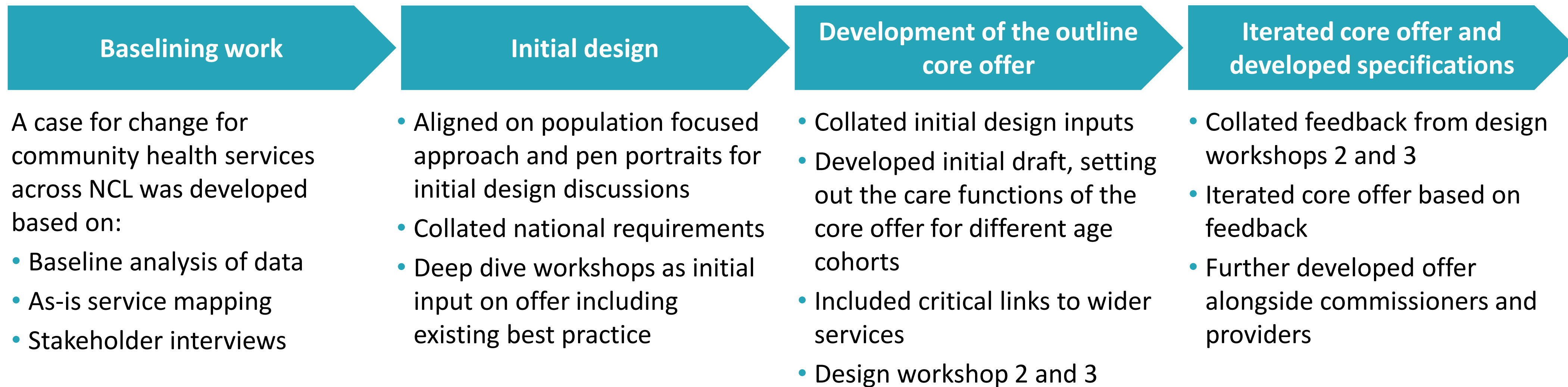
The aim of the reviews is to have a **consistent and equitable core offer for our population** that is delivered at a neighborhood/PCN level based on identified local needs and that is fully integrated into the wider health and care system ensuring outcomes are optimised as well as ensuring our services are sustainable in line with our financial strategy and workforce plans.

Objectives:

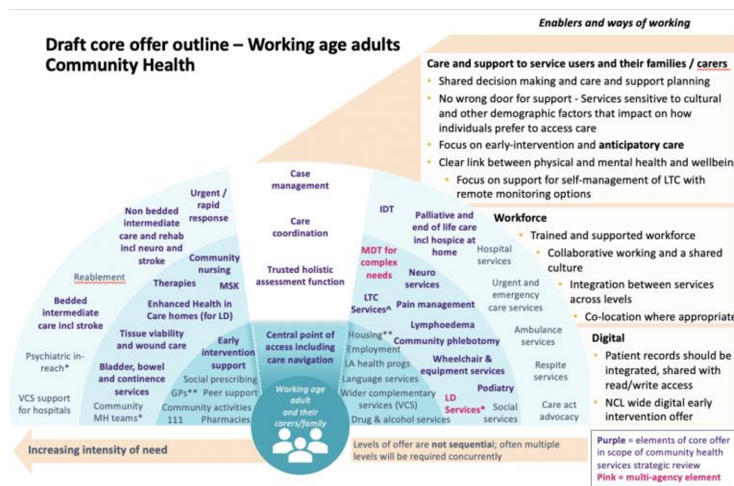
- Provision of a core & consistent offer that is delivered locally based on identified needs and that addresses inequalities and inequities of access and health outcomes
- Provision of community and mental health services that optimises the delivery of care across NHS Primary, Secondary, Tertiary services and the wider system with Local Authority and Voluntary & Charitable Sector (VCS) partners and services
- Moves us closer to the national aspirations around the delivery of care Out of Hospital where clinically appropriate and ensuring it is as accessible as possible
- Ensure we deliver on national Must Dos for community and mental health services

In Scope
All **NHS funded community services** (meaning Adult and Children and Young People services delivered outside of a hospital setting and not part of an Acute Spell) delivered by both NHS Community and Acute Providers. All **NHS funded mental health services** (including Perinatal, Children and Young People, Adults and Older Adults and People with a Learning Disability).
All NHS funded community services delivered by Private and other Providers (Voluntary and Charitable Sector, etc). This includes **community services delivered by Primary Care** partners that are not part of a Primary Care Core Contract, Locally Commissioned Service/Directed Enhanced Service or similar arrangement.
The scope also includes services such as Discharge (Integrated Discharge Teams), End of Life Care, **services for people with Long Term Conditions where these are funded by the NHS** and delivered outside an acute episode of care.

Approach to development of the core offer for community health services



Through this process, a core offer outline was developed for different age segments of the population and specifications were drafted for each care function of the core offer



Example core offer outline showing all services

Draft specifications

CYP | Working age adult | Older person | Contains national requirement targets

Core offer element: Community health support Long Term Condition management (General requirements for all LTCs)

Overview

Description of the element

Expectation that Long term care management is mostly led by primary care. Specialist community care LTC services supports those patients with complex needs:

- Provide advice and guidance to primary care and other services
- Provide specialist holistic assessment and support care planning
- Provide specialist therapeutic support when required
- Facilitate specialist structured education, and self management programmes, peer support programmes and psychoeducation
- Utilises remote monitoring

Capabilities required	Who the element is for	How the element is accessed
Specialist competencies for each long term condition. Psychology and occupational therapy in each team. Trained to deliver self management programmes	Patients with long term conditions. Support is both for patients and for the primary care professionals specifically looking after them	Primary care and district nurse referral. Referral from acute services Self referral and patient initiated follow up are vital

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Virtual/telephone advice, community clinics, leisure facilities	9-5 Mon-Fri for routine support with flexibility; out of hours provided by district nursing and 111	2 weeks	2 weeks for follow up

Integration with wider health and care system

Provide specialist advice and input to primary care without a formal referral being required.

Provide advice, training and support to district nursing and acute services

Closer working relationship with equipment, orthotics and dietetics as required

Contribute to complex care and frailty MDTs as required

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Example specification for single service

The purpose of the core offer is to set out a commitment to the support the NCL population can expect to have access to, regardless of their borough of residence

Purpose of the core offer

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence.

The core offer will provide clarity to the population, clinicians and professionals in the system on what support is available, when it is available and how to access it.

The core offer is:

- A description of care functions and services that should be available across NCL for different age segments of the population and how these care functions integrate with the wider health and care system
- In particular, the core offer provides a brief specification for each care function that describes:
  - What the care function is and what it aims to deliver
  - Operating hours and any out of hours provision
  - Response times for first contact with service user and ongoing contact (in line with national requirements)
  - Who the care function is for and how the care function is accessed
  - Links/ integration with other services and agencies
  - Workforce capabilities required
  - Point of delivery (e.g. in person, virtual)

The core offer is not:

- A detailed specification for how providers should deliver care
- A description of how providers should organise workforce, facilities etc. in order to deliver the core offer

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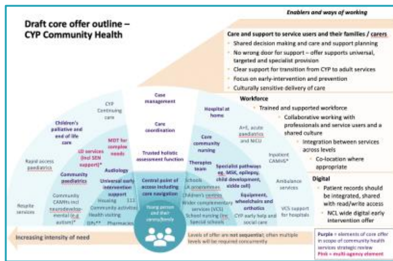
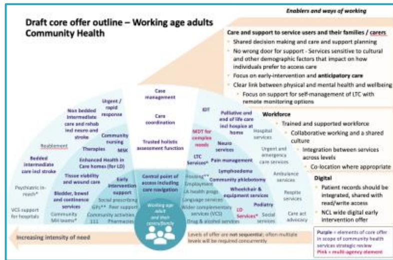
A core offer has been developed for different age segments of the population and consists of core offer outlines, coordinating functions and specifications for services

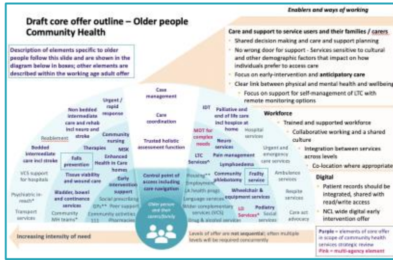
Core offer outlines provide a summary of care functions and services that are part of the core offer for each age profile. The outlines also show care functions not within scope of the review but that should be linked in with the core offer, as well as enablers.



Children and young people



Working age adults



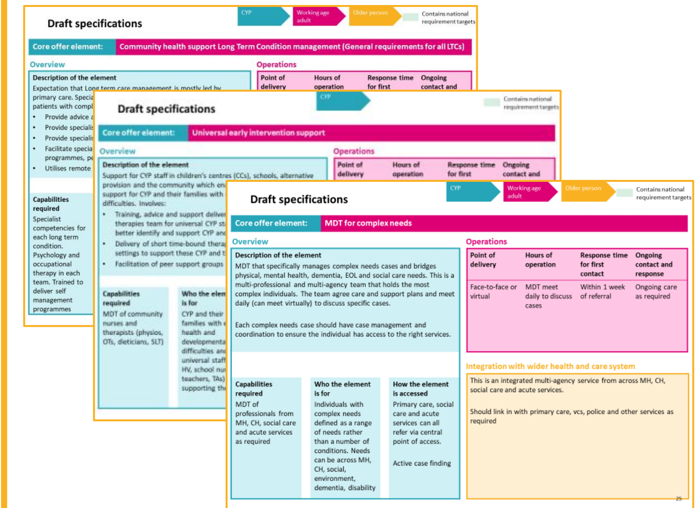
Older people

Each outline also contains a set of **coordinating functions** encompassing a central point of access, care coordination and case management.

Coordinating functions to provide a central point of access, navigation and coordination

Service user and their carers/family

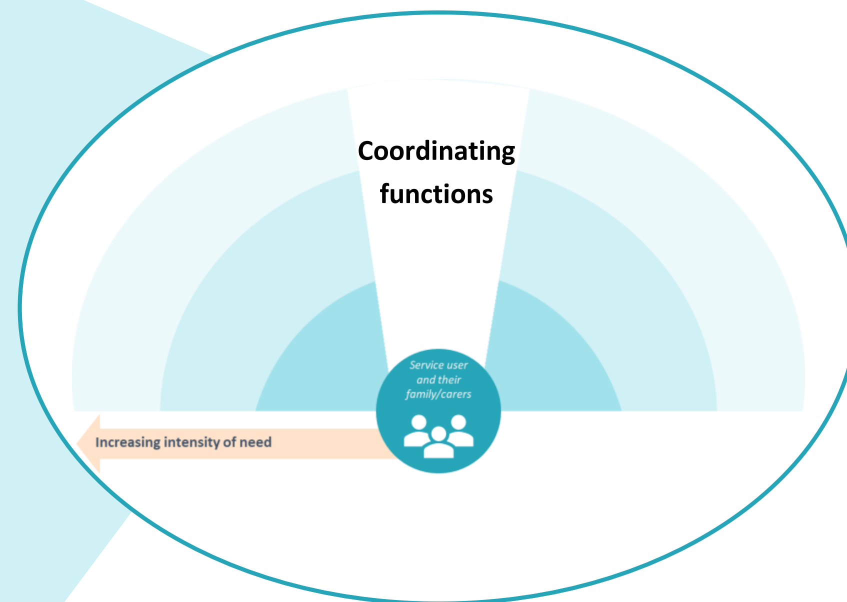
Following each core offer outline, in-scope care functions are further detailed in a set of **specifications**. These provide a description of the care function and lay out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.



The core offer outlines summarise the care functions that should be delivered by community health services with the service user at the heart of the design

Core offer care functions

- Each of the core offer outlines provides a **summary of key care functions** of community health services that should be part of a core offer for age segments of the population
- The care functions are arranged across layers with the **service user and their family / carer at the centre of the offer**
- The further away from the service user, the more intensive the need that the core offer care function provides for
- **Movement between the layers is not necessarily sequential**. Care **delivery can be fluid** and should be delivered where is best for the service user and **as close to home as possible**
- Care functions of the core offer that are in scope of the community services strategic review are shown in **purple and bolded**. The other elements are shown to highlight how services should be integrated across and within the layers
- A set of **coordinating functions run across the layers** helping to coordinate, integrate and navigate care for service users



Enablers and ways of working

- Alongside the core offer outlines, key enablers and ways of working are called out in three areas; care and support to service users and their families / carers, workforce and digital
- These enablers will be further examined and expanded upon through transition and implementation planning

Care and support to service users and their families / carers
Workforce
Digital

Specifications for each care function of the core offer follow the outlines. A description of the coordinating functions is in a separate sectio

Specifications for each care function of the core offer provide an overview of what the care function is and the minimum requirements for its delivery NCL-wide

Draft specifications

CYP | Working age adult | Older person | Contains national requirement targets

Core offer element: **MDT for complex needs**

Overview

Description of the element

MDT that specifically manages complex needs cases and bridges physical, mental health, dementia, EOL and social care needs. This is a multi-professional and multi-agency team that holds the most complex individuals. The team agree care and support plans and meet daily (can meet virtually) to discuss specific cases.

Each complex needs case should have case management and coordination to ensure the individual has access to the right services.

Capabilities required	Who the element is for	How the element is accessed
MDT of professionals from MH, CH, social care and acute services as required	Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, dementia, disability	Primary care, social care and acute services can all refer via central point of access. Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

This is an integrated multi-agency service from across MH, CH, social care and acute services.

Should link in with primary care, vcs, police and other services as required

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- The aim of the specifications is to **provide a level of consistency and equality of access across NCL**
- The specifications **do not detail how providers should deliver the service**, but rather describe minimum standard requirements around:
  - Where the care function should be delivered
  - When the care function should operate
  - Waiting times for first and ongoing contact
  - Thresholds for service user access
  - Capabilities of the workforce
  - How service users can access the care function
- The specifications also provide an overall description of the care function and how it should link in with the wider health and care system
- It should be recognised that there will **be differences in the scale of provision at a local level**, to align with variation in need at a local level and to integrate with local models of care delivery (e.g. through PCNs), but these minimum standards described in the specifications remain consistent across NCL

Digital is a fundamental enabler to the delivery of the core offer

A digital element forms part of the core offer and is integrated throughout the specifications. This could include:

Digital self-help, support and advice services for service users

- NCL wide digital early intervention offer
- Advice, sign-posting, and self-help information for service users, their family / carers and other professionals
- Digital care and support planning to enable individuals to identify goals that matter to them

Virtual services and technology to help patients manage their conditions

- Option to have consultations and triage virtually, building on capabilities implemented during COVID
- Virtual MDTs and staff meetings to increase efficiency
- Technology-enabled solutions (including remote monitoring) that help patients better manage their conditions and receive support when needed in a timely manner

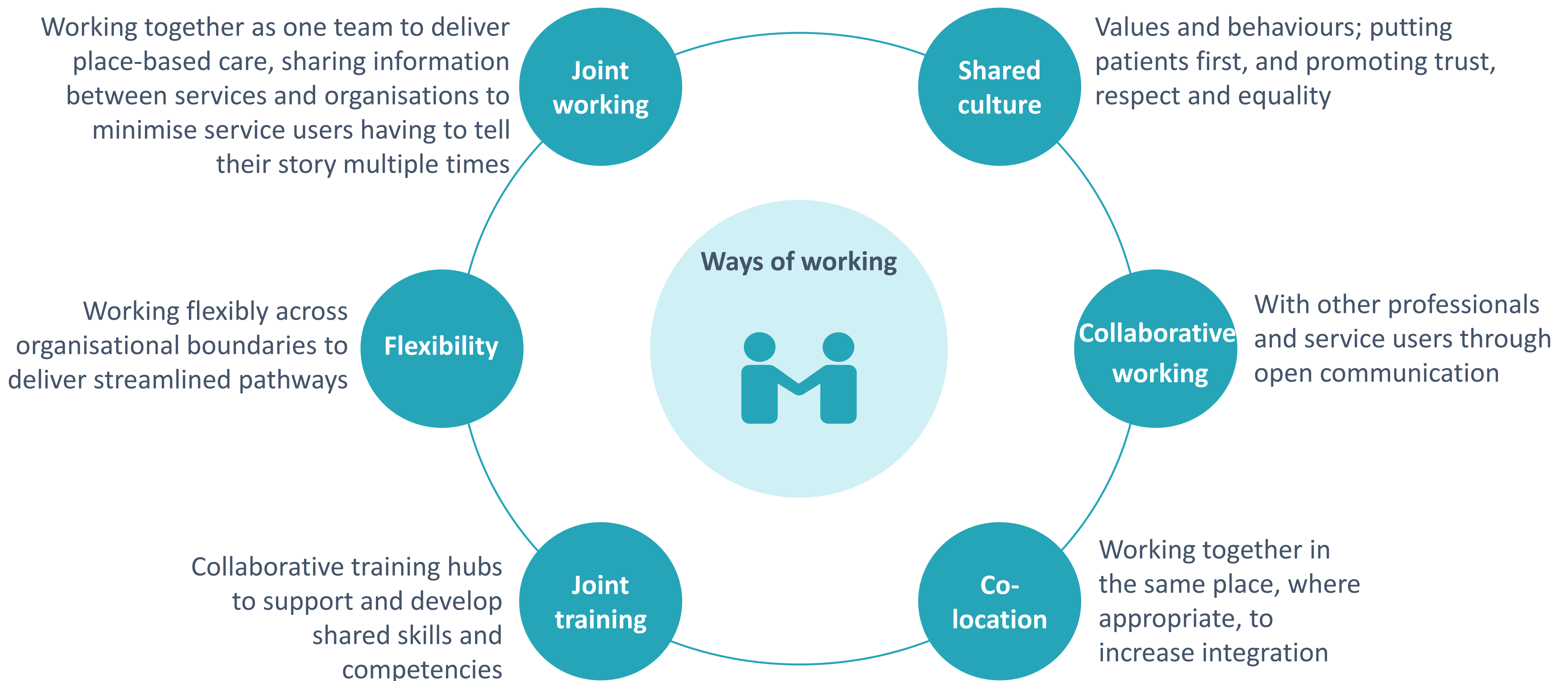
Shared care records and interoperable systems

- Patient records that are integrated, and shared between services and organisations
- Accessible to service users and the appropriate professionals in a timely manner to enable informed individual care planning
- Common structures around digital data across providers

Further work will be required at implementation planning stage to develop the plans to deliver digital transformation to support the core offer. This could be supported by the development of a digital workstream to support the Community and Mental Health Strategic Reviews.

Integrated ways of working across community health, mental health and other agencies will be central to implementation of the core offer

Workforce transformation to support delivery of the core offer could include:

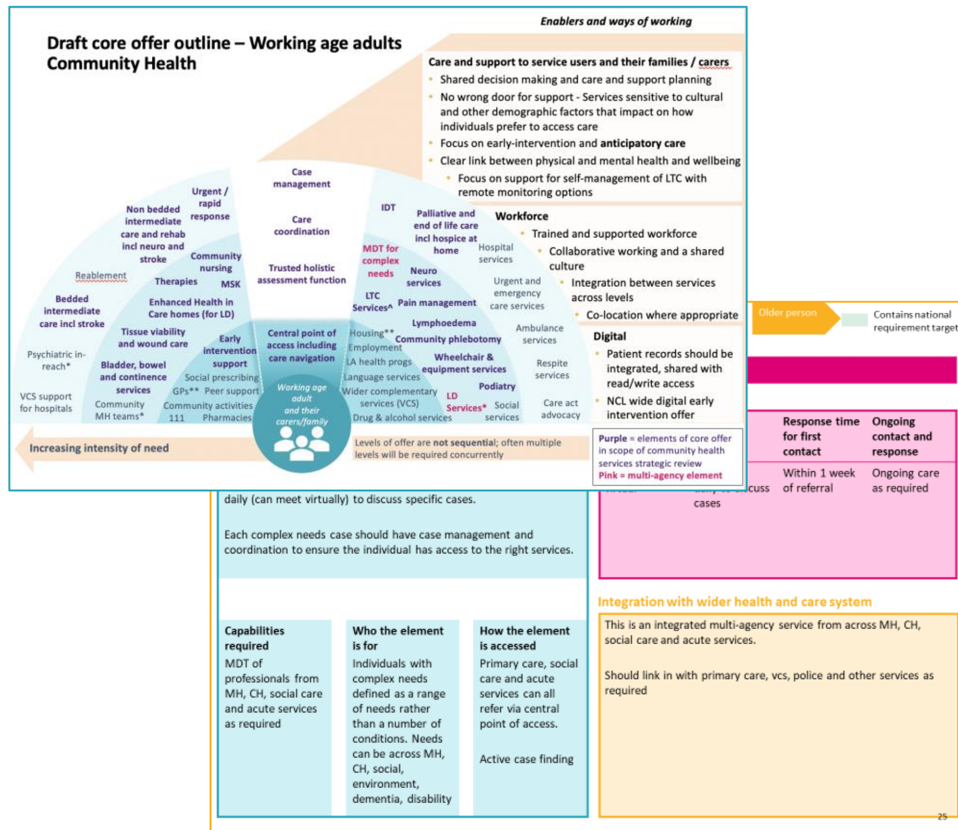


Further work will be required at implementation planning stage to develop the plans for workforce transformation to support the core offer.

The core offer is aligned to other programmes focused on transforming community services in NCL

- Development of the core offer for community services has **not been done in isolation**, with co-production with other programmes of work that are related to the community health services transformation
- The purpose of this review is to **bring together the aspiration for NCL-wide Mental Health and Community Health Services into one place**
- This **supports ongoing areas of work** that are looking at specific aspects and services, for example:
  - Ageing well
  - P2 bed planning
  - Children's therapies and community nursing
- These and other areas of related work will be further **progressed in response to the strategic level core offer**

The core offer will be taken forward to feed into an impact assessment and planning for transition



- The core offer outlines, coordinating functions and specifications that have been developed are intended to be carried forward into:
  - An impact assessment which will be a comparison of the core offer against current provision across several domains including access and finance
  - A transition plan that will cover:
    - The level of delivery of different care functions of the offer i.e. PCN, place, ICS
    - Requirements for enablers to deliver at PCN, place and ICS level
    - Roadmap for transition
    - Recommendations for commissioning
- The core offer will not prescribe to providers how they should deliver against the requirements or how providers should organise themselves to deliver the offer

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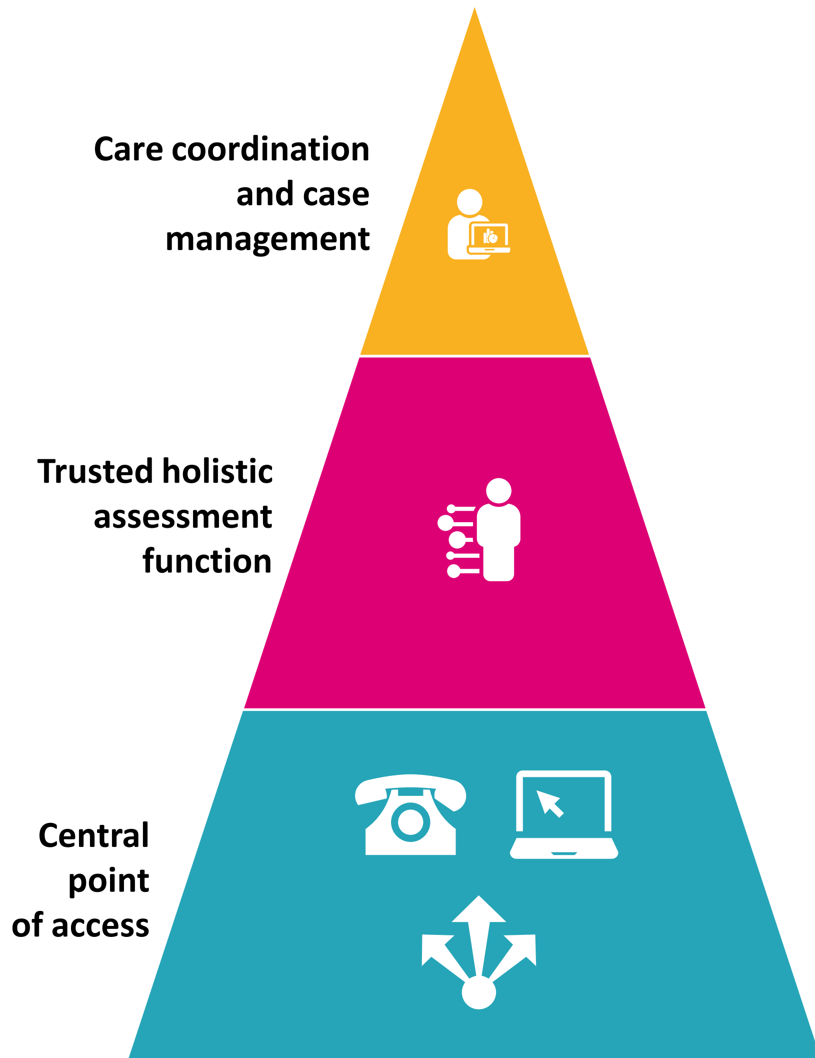
A set of coordinating functions act to support, integrate and navigate care for service users across the layers of the core offer



- Service users with complex needs are allocated a clinical **case manager**. This individual leads the development of a **holistic care plan and its delivery**
- Care coordinators support this through **organising MDT meetings** and supporting service users and their families and carers to **navigate health and care appointments**

- Service users have **a single up front holistic assessment of their health needs, functioning, living environment & preferences**
- This is conducted by a senior professional with trusted assessor competencies who has the trust of the full MDT
- Service users and their families and carers **only have to tell their story once**

- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health or care professionals, by service users and families / carers
- Administrators have access to directory of local services and assets and are able to **help service users and professionals navigate the wider available support**

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Central point of access (including care navigation)	Health and care professionals referring service users to community health services or seeking advice and guidance Service users and their carers and families self referring	Acts as a single point of contact at a borough or NCL level for initial referrals and contacts with local community services The main purpose of the central point of access is to move people seamlessly through services Services also have the ability to move service users to another service (e.g. where a service identifies a patient need that can be covered by another core offer care function)	Telephone and/or email hub which can direct referrals or queries to the right individual or service Borough level Care navigators help people making contact to understand what community health services and wider health and care and VCS services are available and would be most appropriate	Administrators with clear standard operating procedures Non-clinical care navigators who have a directory of services and excellent working knowledge of available services and assets within the borough Central point of access needs to be the most responsive with the ability to provide crisis assessment and request crisis response (if required) in a timely manner	All care functions of community health offer

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Trusted holistic assessment function	Service users with complex health and care needs	Ensure that service users with complex health and care needs can have a single up front assessment of their health and care needs to enable an initial holistic care plan to be co-developed. Ensures that service users and their families and carers don't have to keep telling the same story	Senior professionals within community health services working with service users with complex needs are able to deliver holistic assessments which are trusted by professionals from other services Important to note that subsequent assessments are likely to be necessary to refine diagnosis and/or support further development of treatment plans	Capability to assess the different health and care needs of service users and for this assessment to be trusted by other members of the MDT involved in the service user's care	Management of service users with complex health and care needs

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Care coordination	Service users with complex health and care needs who require the support of multiple community health services	Ensure that the multiple services and individuals involved in the care of a service user with complex needs are aware of what each are doing and are able to deliver holistic joined up care	Support the administration of MDT meetings and discussions Support service users and their families and carers to navigate appointments and to understand the role of each	Administrators who are able to support both service users and their families and liaise with different professional stakeholders	MDTs for service users with complex needs
Case management	Service users with complex health and care needs who require the support of multiple community health services	Support service users with complex health and care needs to have joined up holistic care	Lead the co-development of holistic care plans for service users with health and care needs Accountable for ensuring that different services and professionals are supporting the delivery of this plan	Senior health or care professional who is allocated to patients. Can be from any professional health and care background but must be able to provide trusted holistic assessments	Service users with complex health and care needs

Patient initiated follow up could be a tool to support service users to navigate the core offer and access support when required

Following an appointment, it is often necessary to arrange follow-up appointments for ongoing care. Traditionally, these appointments are offered at routine intervals but in some cases, patients might need a follow-up appointment sooner than their scheduled session or they may agree with their clinician that a follow-up is not required unless their symptoms flare up or their circumstances change.

Patient initiated follow-up (PIFU) is giving patients and their carers the **flexibility to arrange their follow-up appointments** as and when they need them. PIFU can be used with **patients with long or short-term conditions** and following treatment or surgery. This gives patients access to care and support when they need it, whilst avoiding unnecessary trips to hospitals and clinics, saving them time, money and stress.

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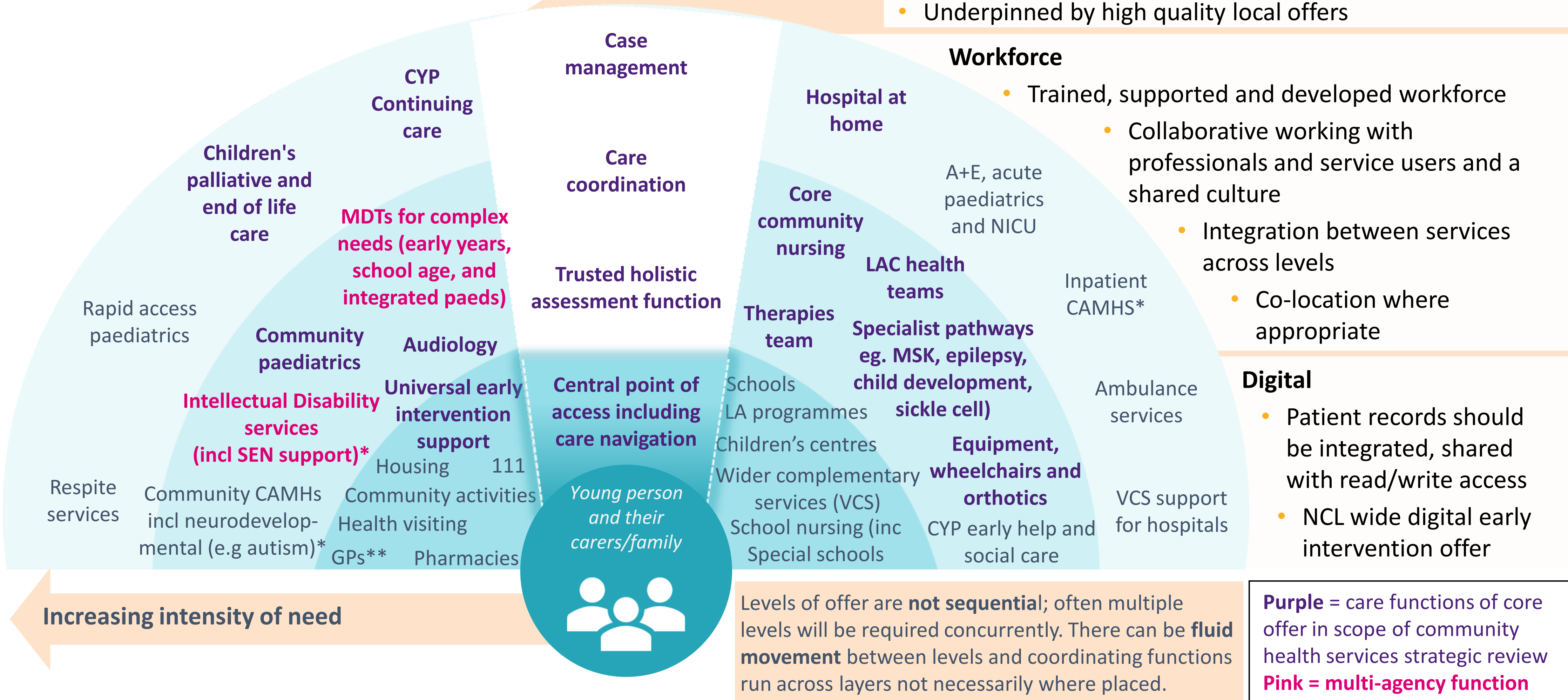
CYP

Draft core offer outline – CYP Community Health

Care and support to service users and their families / carers
- Shared decision making and care and support planning
- No wrong door for support – offer supports universal, targeted and specialist provision. Therapy / care delivered where needed in a culturally sensitive manner
- Clear support for transition from CYP to adult services
- Focus on early-intervention and prevention
- Underpinned by high quality local offers

Workforce
- Trained, supported and developed workforce
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital
- Patient records should be integrated, shared with read/write access
- NCL wide digital early intervention offer



Levels of offer are **not sequential**; often multiple levels will be required concurrently. There can be **fluid movement** between levels and coordinating functions run across layers not necessarily where placed.

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Described as part of mental health core offer
**GPs and broader primary care team including extended roles

CYP community health services are delivered under universal, targeted and specialist offers

Universal offer

Description

The universal offer describes a way of working at the earliest opportunity in order to prevent escalation of needs. This offer is universally available to all CYP and their families / carers. The offer focuses on early intervention and prevention and is delivered through training and support to CYP staff (universal professionals, e.g. in schools, children's centres, early years settings, etc.) in a variety of settings. The universal offer helps to support CYP staff with early identification of need and provides direct training and assistance in how to manage those early needs. Qualified professionals are embedded within CYP settings and can be easily accessed for advice, assessment and short, direct interventions. Examples of short interventions include sensory playgroups, where CYP staff can be trained to deliver these interventions following on from the first intervention. The universal offer also includes health visiting and school nursing (although these are out of the scope of this core offer)

The universal offer has a dual role to support the child / young person and to upskill staff working with CYP so that they can recognise early need, deliver short interventions themselves and prevent escalation. Identification of and safeguarding children from harm underpins the universal, targeted and specialist offers. Designated Safeguarding and LAC Dr and Nurse roles help ensure effective safeguarding is embedded into practice. Practitioners from across disciplines take part in multi-agency Team Around the Child care planning. Designated Clinical Officers and Drs for SEND help ensure compliance with SEN statutory requirements.

Capabilities required

Workforce available in all areas to deliver universal offer. Qualified professionals available to train, give advice, support, help with escalating need and referrals

Who the care function is for

All CYP and their families

How the care function is accessed

Open access, no referral needed (integrated working; part of a team, MDT at a universal level).

Universal setting (no wrong door)

Early-help hubs

Contains national requirement targets

Draft specifications

Universal offer care function: Early intervention support

Overview

Description of the care function

Support for CYP staff in children's centres (CCs), schools, alternative provision and the community which enables early identification and support for CYP and their families with developmental and health difficulties. Involves:

- Training, advice and support delivered by community nursing and therapies team for universal CYP staff which enables them to better identify and support CYP and families at an earlier stage
- Delivery of short time-bound therapeutic interventions in these settings to support these CYP and their families
- Facilitation of peer support groups

Capabilities required

MDT of community nurses and therapists (physios, OTs, dieticians, SLT)

Who the care function is for

CYP and their families with early health and developmental difficulties and the universal staff (incl Health visitors, school nurses, teachers, TAs) supporting them

How the function is accessed

Early intervention MDT allocated to group of CC, schools and alternative provision at a PCN footprint

CYP and their families can also self refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
CCs, schools, alternative provision, virtual / telephone advice	Mon-Fri 9-5 with some flexibility for training and support	1 week response	As required

Integration with wider health and care system

Early intervention team provides support and training to universal professionals across CC, schools and alternative provision

It links into core targeted community and therapies support and specialist pathways as required removing need for formal referral

Draft specifications

Contains national requirement targets

Universal offer care function: CYP Audiology (Universal and specialist)

Overview

Description of the care function

Universal newborn hearing screening teams which are based within the acute paediatric departments across NCL.

Assessment, management and treatment and rehabilitation of children and young people presenting with a hearing loss, tinnitus and balance disorder

Capabilities required	Who the care function is for	How the function is accessed
Audiologists and technicians	All newborn children (universal) CYP with concerns about hearing loss or balance disorders (specialist)	Postnatal wards, paediatric teams

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Postnatal wards, vlinic rooms	8-8 Mon-Sun	Same day for new born screening	As required, but up to twice weekly review

Integration with wider health and care system

Close links with paediatric teams. Work closely with specialist ENT services required at the Royal National ENT hospital.

Works alongside health visitors and school nursing teams as well as CYP social work teams. Contributes to SEND assessments and MDT discussions and planning

CYP community health services are delivered under universal, targeted and specialist offers

Targeted offer

Description

The targeted offer provides a range of services for children and young people that require further support beyond or in addition to the universal offer. The offer provides assessments, that can be face-to-face or virtual, of a child's overall strengths and needs in relation to the reason for their referral.

The targeted offer also provides interventions in various settings and formats including group, family, parent, schools etc. Both assessments and interventions are delivered in a timely manner as set out in the detailed specifications following this page.

These targeted interventions can be individual or thematic for a particular target group.

The aim of the targeted offer is to provide support for physical needs in the community and work together with mental health services in order to prevent escalation of needs.

Identification of and safeguarding children from harm underpins the universal, targeted and specialist offers. Designated Safeguarding and LAC Dr and Nurse roles help ensure effective safeguarding is embedded into practice. Practitioners from across disciplines take part in multi-agency Team Around the Child care planning.

Designated Clinical Officers and Drs for SEND help ensure compliance with SEN statutory requirements.

Capabilities required

Community nurses, paediatricians, OT, SLTs, PTs, dietitians

Who the care function is for

CYP (and their family) identified as having a need that cannot be supported only through universal offer

How the care function is accessed

Referral through central point of access

CYP

Contains national requirement targets

Draft specifications

Targeted offer care function: CYP core community nursing

Overview

Description of the care function

- Core community nursing provides holistic assessments and co-develops treatment plans for CYP and families that require support beyond the universal offer
- Core community nursing support includes wound care including tissue viability, administering drugs, passing NG tubes and respiratory support
- Core community nursing support includes bowel and bladder care (including night time enuresis care)
- The team contributes to Team around the Child and MDT discussions
- The team links in with specialist community pathways as required
- Provide training to manage community based ventilators and other specialist breathing equipment

Capabilities required

Community nurses can give IV antibiotics, manage IV bloods, manage and access Hickman's lines / ports, administer controlled drugs and catheterize and manage ventilators and specialist breathing equipment

Who the care function is for

CYP incl LAC and their families with short and longer term additional and complex needs (These CYP may also need additional support from specialist pathways)

How the function is accessed

Primary care, school nurses, health visitors and social care and acute paediatrics can all refer via central point of access. CYP and families can also self refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and Children's Centres, acute wards	Community nursing 8-10pm Mon-Sun	1 day for urgent response, 1 week for non urgent	Up to daily review as required

Integration with wider health and care system

Team needs to link in with the universal community health offer. It can access specialist CYP community health pathways when CYP and their families need additional specialist input

Team works alongside wider professional network support CYP and their families including social care (and early help), school and Children's Centre staff, acute paediatrics and primary care

Each team is linked to a group to primary care networks

Draft specifications

CYP

Contains national requirement targets

Targeted offer care function: CYP therapies delivered by AHPs (also supports universal and specialist)

Overview

Description of the care function

Occupational therapy, physiotherapy, dietetics and speech and language assessments and interventions for CYP with functional impairment or disability. This is for both those with long term conditions and with urgent health and care needs. The therapies service also provides training and support to empower and help build the resilience of CYP and their families / carers and to enable them to help support and provide care. May work with specialist pathways eg to undertake some diagnostic assessments of children with neurodevelopmental concerns eg autism

Key role contributing to SEND assessments and delivery within EHCPs.

Capabilities required	Who the care function is for	How the function is accessed
Range of assessment and therapeutic competencies across AHPs	CYP and their families with LTCs, those with urgent care needs and those requiring rehabilitation support (These CYP may also need additional support from specialist pathways)	Schools, children's centres (CCs), Health visiting, primary care, community nursing, school nursing and Paediatrics can access via single point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and CCs, acute wards	9-6 Mon-Fri with some flexibility	First contact 4-6 weeks or 12 weeks for ASD assessment Urgent appointments for those with dysphagia/eating/drinking concerns	Up to daily review as required, dependent on CYP's needs

Integration with wider health and care system

- Daily working relationships with community nursing, primary care health visitors and school nursing, early years, education, social care and voluntary sector teams.
- Integrated health and mental health teams around locality networks
- Integrated working with Local Authority SEND teams contributing to assessments and MDT discussions and reviews
- Works with orthotics and equipment service and Local Authority transport team

CYP | Working age adult | Older person | Contains national requirement targets

Draft specifications

Targeted offer care function: Equipment, wheelchairs and orthotics

Overview

Description of the care function

Wheelchair

Clinic and home assessments of CYP and adults with ongoing disabilities.

Equipment and Orthotics

Functional assessment of CYP with short term and ongoing disabilities. Assessment and provision of equipment and wheelchairs and implementation of required home adaptations. Support and training to use equipment. Regular review of changing needs. Includes orthotic assessment of CYP with disability and provision of appropriate orthoses. Community Equipment covers a range of items that are provided in people's homes to support independence. It includes commodes, hoists, grab rails and other items.

The service does not have hours of operation, but is rather contracted to deliver equipment within specified timeframes, e.g. 1-7 days, depending on the urgency of the request.

Capabilities required	Who the care function is for	How the function is accessed
OTs, physiotherapy rehab engineers, equipment and orthotists and prosthetists	CYP with a disability	Community health services, social care practitioners, education facilities rehab facilities, paediatrics, CYP social care and primary care can access service for patients

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community, clinic and care homes. Able to deliver to patient homes	**Urgent Equipment** 7 day service **Wheelchairs and orthotics** 9-5 Mon-Fri out of hours emergency repair service 7 days	Same day for urgent referrals (excluding orthotics) Rest dependent on service and level of need	Reflecting individual pathways and care plans

Integration with wider health and care system

Works alongside all community, acute, social care VCS and primary care services. Also links to Hospital at home and palliative care services

CYP

Contains national requirement targets

Draft specifications

Targeted offer care function: Community paediatrics (also supports specialist offer)

Overview

Description of the care function

Provision of medical assessments and interventions in the community for CYP and their families with developmental delays and disorders including conditions such as epilepsy, autism, Down Syndrome and cerebral palsy.

Community paediatrics works closely with other members of the community targeted and specialist offers, early years, schools and primary care to assess and meet the health needs of CYP with developmental disorders, disabilities or special needs. They also work alongside and provide medical advice to Local Authority special educational needs services and social care services. This includes advice regarding potential safeguarding concerns. Deliver safeguarding medical assessments and undertake health assessments and reviews for Looked After Children

Capabilities required	Who the care function is for	How the function is accessed
Consultant and trainee community paediatricians	CYP and their families with targeted of specialist community health needs who require medical assessment and intervention	Via community nursing and therapy teams; via specialist pathways; via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community paediatric clinics, wellbeing hubs,	9-5 with out of hours on call provision for emergency safeguarding concerns	12-18 weeks for first appointment	As required

Integration with wider health and care system

Core member of Team around Child MDTs supporting CYP with targeted and specialist needs

Provide advice and support to universal professionals including primary care, CAMHS, health visitors and school nursing

Integrated with local acute paediatric services and social care

Draft specifications

CYP

Contains national requirement targets

Targeted offer care function: Looked After Children's Health teams

Overview

Description of the care function

Provision of nursing and medical assessments and reviews for Looked After Children.

- Undertaking and/or quality assuring Initial Health Assessments and Review Health Assessments in line with statutory timescales,
- Diagnosis, health management and promotion, referral and follow up
- Liaison with other health, education and social care pathways including CAMHS and primary care
- Training on health needs for foster carers, education, social care and other partners

Capabilities required

Consultant and trainee community paediatricians, nursing

Who the care function is for

Looked After CYP and their carers

How the function is accessed

Via social care referrals; via specialist pathways; via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community paediatric clinics, wellbeing hubs,	9-5 with out of hours on call provision for emergency safeguarding concerns	IHAs within 20 days Reviews 6 monthly for U5s / annual CYP 5+	As required

Integration with wider health and care system

Close joint working with social care.

Provide advice and support to universal professionals including primary care, health visitors and school nursing. Advising GPs and other practitioners on outstanding immunisation and child health surveillance programmes for children. Integrated with local acute and wider community paediatric services

CYP community health services are delivered under universal, targeted and specialist offers

Specialist offer

Description

The specialist offer generally provides more long-term support to children and young people and their families / carers with ongoing and / or complex needs. However, the specialist offer can also provide acute, intensive and short-term interventions where required. The offer provides specialist assessments and direct therapeutic interventions.

CYP with needs requiring specialist input do not necessarily have to cycle through the offers sequentially from universal, to targeted to specialist. For example, a premature baby would require immediate specialist care.

The specialist offer also acts to provide advice and input to other agencies and services, particularly primary care and helps to support self-management. Delivered with and through settings and schools where the infrastructure has been developed to support children with additional, specific or complex needs

The aim of the specialist offer is to provide support to CYP and their families / carers in the community to prevent escalation and maximize potential. Identification of and safeguarding children from harm underpins the universal, targeted and specialist offers. Designated Safeguarding and LAC Dr and Nurse roles help ensure effective safeguarding is embedded into practice. Practitioners from across disciplines take part in multi-agency Team Around the Child care planning.

Designated Clinical Officers and Drs for SEND help ensure compliance with SEN statutory requirements.

Capabilities required

Specialist knowledge and skills. Clinical nurse specialists (CNSs) and therapists. Specialist knowledge across teams to include mental health, substance misuse, young parents and sexual health issues. Must know Local Offer and local services.

Who the care function is for

CYP (and their family) identified as having a need that cannot be supported through universal and targeted offers (driven by complexity of need that requires number of professionals to help support those needs)

How the care function is accessed

Referral through central point of access and/or from community professionals already providing targeted support, , or progression through a multidisciplinary pathway of care

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function: Specialist CYP Community health pathways

Overview

Description of the care function

Specialist community health pathways for CYP and their families with specialist needs beyond) that provided by core targeted team

- Pathways include specialist MSK, epilepsy, diabetes, sickle cell, specialist school nursing and child development, hospital at home
- Provide advice and guidance to primary care and other services
- Provide specialist assessment and therapeutic interventions
- Facilitate specialist structured education, and self management programmes, peer support programmes and psychoeducation
- Support the emotional and physical wellbeing of CYP and their families
- Includes support to enable CYP to be supported in community as opposed to paediatric outpatients

Capabilities required

MDT of community nurses and therapists (physios, OTs, dieticians, SLT)

CYP clinical psychologist for appropriate pathways

Who the care function is for

CYP and their families with short or long term health conditions needing support from specialist teams

How the function is accessed

Core team "steps-up" to specialist pathways as required. Also can be accessed directly for advice and assessments by primary care, health visitors and school nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and CCs, acute wards	9-5 Mon-Fri for routine support with flexibility; out of hours provided by core team	2 weeks	As required

Integration with wider health and care system

Teams work at borough or NCL level and need to work closely with core (targeted) teams working with each group of PCNs. They also need to link in the early intervention (universal) community health offer and universal services.

Team works alongside wider professional network support CYP and their families including social care (and early help), school and CC staff, acute paediatrics and primary care. May be delivered through age related pathways.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function: CYP Continuing care

Overview

Description of the care function

- Core specialist nursing in the community provides holistic **assessments, develops care plan, undertakes annual reviews, lead on quarterly quality reviews of care and provide training for professionals who care** for CYP with complex needs in line with the national Continuing Care Framework. This includes CYP who have a PHB.
- Where contracted, the continuing care service will also deliver high quality packages of individualsied care and support to CYP in the community
- Nurse led service
- Integrated panel for decision making for provision across health, social care and education
- The team links in with specialist community pathways as required

Capabilities required

Community nurse led

Trained in use of Children's Continuing Care Framework

Who the care function is for

CYP and their families with significant, longer term additional and complex needs who meet continuing care criteria. (These CYP may also need additional support from specialist pathways

How the function is accessed

Referral for assessment against criteria in Children's Continuing Care Framework

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Family homes	Community nursing 8-10pm Mon-Sun	In line with NCL Children's continuing care policy. Continuing Care DST tool completed within 6 weeks.	Up to daily review as required, depending on clinical need and in line with care plan.

Integration with wider health and care system

Team needs to link in with a variety of professionals across health, education and social care. The team will access specialist CYP community health pathways when CYP and their families need additional specialist input or support. This may include end of life care and bereavement support.

Panel works alongside wider professional network to support CYP and their families including social care (and early help), school and Children's Centre staff, acute paediatrics and primary care

CYP

Contains national requirement targets

Draft specifications

Specialist offer care function: CYP Disability and Complex Needs MDT Pathways: Early Years

Overview

Description of the care function

Specialist multi-disciplinary health pathways for CYP and their families with emerging or diagnosed developmental and/or neurodevelopmental concerns and disabilities, closely integrated with social care and education. Often known as Child Development teams or services:

- Provide advice and guidance and joint consultations to primary care and other services
- Provide specialist multi-disciplinary assessment and review plus interventions eg therapies, feeding/eating support, continence, sleep, whole family mental health support
- Access to keyworking/case co-ordination function
- Facilitate specialist structured education, self management, peer support programmes and psychoeducation
- Support the emotional and physical wellbeing of CYP and their families

Capabilities required

MDT of paediatricians, therapists (physios, OTs, dieticians, SLT), specialist nursing, CAMHS clinicians. Multi-agency liaison function.

Who the care function is for

CYP and their families with developmental and/or neurodevelopmental concerns or disabilities

How the function is accessed

Core team "steps-up" to specialist pathways as required. Also can be accessed directly for advice and assessments by primary care, health visitors and school nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and CCs, acute wards	9-5 Mon-Fri for routine support with flexibility; out of hours provided by core team	2 weeks	As required

Integration with wider health and care system

Teams work at borough level and need to work closely social care and education. They also need to link in the early intervention (universal) community health offer and universal /targeted services.

Teams undertake assessment of children undergoing Statutory Assessment for SEN needs.

Also work with wider professional network supporting CYP and their families including early help, school and CC staff, acute paediatrics and primary care.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function: CYP Disability and Complex Needs MDT Pathways: School Age

Overview

Description of the care function

Specialist multi-disciplinary health pathways for disabled CYP and their families and/or for those with complex LD, autism and/or behavior that challenges. Based predominantly in schools or closely integrated with education and social care for this group:

- Provide advice, guidance and training to schools, primary care and other services
- Provide specialist joined up multi-disciplinary assessment and review plus interventions
- Develop, implement and monitor health input into Education, Health and Care plans including a single Health outcomes-based support plan
- Facilitate specialist structured education, and self management programmes, peer support programmes and psychoeducation
- Support the emotional and physical wellbeing of CYP and their families

Capabilities required

Specialist school nurses paediatricians, therapists (physios, OTs, dieticians, SLT), CAMHS clinicians /LD &MH nurses

Who the care function is for

CYP and their families with developmental and/or neurodevelopmental concerns or disabilities

How the function is accessed

Core team "steps-up" to specialist pathways as required. Also can be accessed directly for advice and assessments by primary care, health visitors and school nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Schools, community clinics, family homes	9-5 Mon-Fri for routine support with flexibility; out of hours provided by core team	2 weeks	As required

Integration with wider health and care system

Integrated health Teams work at borough level and need to work closely with education and social care and to support transition into adult services. They also need to link in the early intervention (universal) community health offer and universal services. Also work with wider professional network supporting CYP and their families including early help, school and CC staff, acute paediatrics and primary care.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function: Paediatric Integrated Care MDTs

Overview

Description of the care function

Locality based multi-disciplinary working arrangements that specifically guide cases where needs are complex or in need of multi-agency input. Bridges physical, mental health, education and social care needs. This is a multi-professional and multi-agency meeting that provides advice and guidance. The team shape care and support plans and meet (can meet virtually) to discuss specific cases.

Each case should have case management and coordination to ensure the individual has access to the right services.

Capabilities required

MDT of professionals from Primary Care, MH, CH, social care and acute services as required

Who the care function is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, disability

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

This is an integrated multi-agency service from across MH, CH, schools, CYP social care, primary care and acute services.

Should link in with VCS, police, YOT and other services as required

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function: Hospital at home (Specialist community health pathway)

Overview

Description of the care function

Enhanced nursing model embedded within existing Children's community nursing team. It supports both hospital avoidance and more effective and speedier discharge into the community across a range of conditions by providing acute care at home

This involves home based acute care delivered by children's nurses with acute paediatrician supervision. It includes support and education for families to enable them to support care provision

Capabilities required

Advanced nurse practitioners with advanced assessment skills, who can take bloods, cannulate and give IV antibiotics, Acute paediatrician supervision.

Who the care function is for

CYP at high risk of requiring hospital admission who can be managed at home as an alternative to hospital

How the function is accessed

Referrals from primary care, paediatric A+E, rapid access paediatrics and inpatients

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face to face in CYP's home Or other community venue	8am-10pm 7 days/week	2 hours (*as per LTP targets)*	Daily MDT case discussion and home CYP review up to 3 /day. Support patients for up to 1 week

Integration with wider health and care system

Daily working relationship with rapid access paediatrics, paediatric A+E and inpatient wards, Midwives and other children's community nursing services and continuing health care teams.

Liaison as required with CYP's GP practice and regular communication with GP.

Working relationship with CYP social care, early help, therapies, Continuing Care, community paediatrics, palliative care and General Practice.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function: CYP End of life and hospice care (Specialist community health pathway)

Overview

Description of the care function

- Symptom management support, holistic support, pre and post bereavement support to parents and siblings, anticipatory care planning, support for families
- Provides families with choice of provision. This includes:
- Hospice at home care which involves MDT provision of care within patient's home including support for family, play and work with siblings
- Bedded hospice care provides intensive symptomatic support and care to patients and their family on palliative care pathways. This includes provision of respite care and family facilities.
- Equipment loans
- Therapeutic and holistic support for children with life limiting illnesses and end of life care needs (located in Barnet children's hospice)

Capabilities required

Can administer IVs and prescribe controlled drugs, set up syringe drivers; palliative care consultant supervision, therapy, psychology and social worker input, CHC assessor

Who the care function is for

CYP with life threatening conditions where curative treatment may fail, CYP where premature death is inevitable, those with progressive or severe non progressive conditions

How the function is accessed

Primary care, CYP community nurses and acute inpatient and outpatient services can phone for advice and support and to make referrals. Also accessed via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
CYP's home, hospices, support on acute and wards, or other community venue	8am-8pm 7 days/week for advice and visiting. Out of hours provision 8pm-8am Hospice beds 24/7	Two hour response for urgent referrals, 7 day non urgent	2 hour response for urgent escalations

Integration with wider health and care system

Available for advice, support and provision of training to primary care, CYP community nurses, acute services and care homes

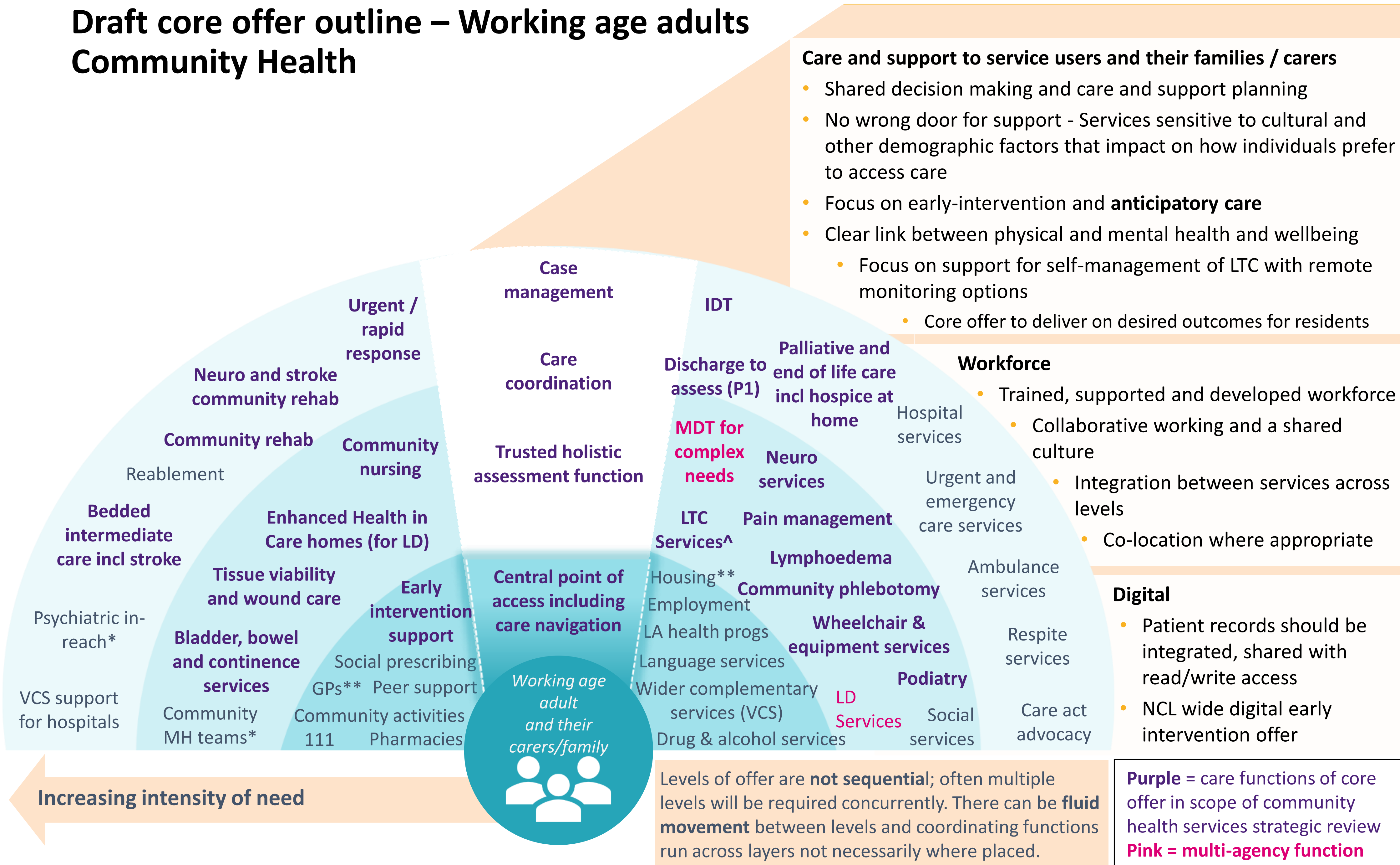
Dedicated contact for each primary care network with team for each borough

Involve primary care in anticipatory care planning

Close relationships with non-NHS funded hospice and community end of life care and play and bereavement specialists enabling involvement at earliest opportunity

Close working relationships with equipment services and pharmacies. Need to have access to input from therapies

Working age adult



^Details for management of specific LTCs are shown in subsequent slides

**Housing including homelessness services

***GPs and broader primary care team including extended roles

In the following specifications, the term ‘housebound’ for service users refers to the draft definition set out below

This draft **definition of ‘temporary housebound’ guidelines** aims to ensure that community nurses teams are providing routine clinical appointments in the home setting only when it is appropriate. It is acknowledged that an individual’s needs may change and therefore eligibility for a home visit should be reassessed on a regular basis.

If patients meet the criteria set out below they are eligible for a home visit for routine treatment:

- A patient is unable to leave their home due to physical or psychological illness
- Post-operative patients who are temporarily unfit to travel
- Patients who require palliative care – this is irrespective of mobility status as it is appropriate for these patients to have care delivered within their home.
- Patients who are undergoing chemotherapy, radiotherapy or who have a health condition where travel or attendance at a community clinic would be detrimental to their health or recovery.
- Patients defined as ‘transport housebound’ - either permanently or temporarily are unable to leave their home unaccompanied to complete purposeful tasks.
- For those patients temporarily housebound, there will be an expectation that once mobile, they will be discharged from service and referred back to GP Practice team should on-going care be required.
- In exceptional cases, receiving teams may use discretion where a patient is assessed as unlikely to engage in any other form of health care. This will need senior approval and be closely monitored.

An individual will generally not be eligible for a home visit if they **are able to leave** their home environment on their own or with minimal assistance to visit public or social recreational public services (including shopping).
Wherever possible patients are encouraged to attend local community venues for their care.

Working age adult

Older person

Contains national requirement targets

Draft specifications

Core offer care function: Early intervention support

Overview

Description of the care function

Support for staff in community centres, alternative provision and the community which enables early identification and support for individuals and their families / carers with developmental and health difficulties. Involves:

- Training, advice and support delivered by community nursing and therapies team for staff which enables them to better identify and support individuals and families / carers at an earlier stage
- Delivery of short time-bound therapeutic interventions in these settings to support these individuals and their families / carers
- Facilitation of peer support groups and support to self manage health and outcomes, supported by psychology/counselling input where needed

Capabilities required

MDT of community nurses and therapists (physios, OTs, dieticians, SLT)

Health trainers, psychology

Who the care function is for

Adults and their families / carers with early health and developmental difficulties and the universal staff supporting them

How the function is accessed

Early intervention MDT allocated at a PCN footprint

Adults and their families / carers can also self refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community centres, service users' home, places of work and study, virtual/ telephone advice	Mon-Fri 9-5 with some flexibility for training and support	1 week response	As required

Integration with wider health and care system

Early intervention team provides support and training to universal professionals across Community Centres, alternative provision and other venues as required.

It links into core targeted community and therapies support and specialist pathways as required removing need for formal referral.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Community/District nursing

Overview

Description of the care function

Provide 24 hour care to housebound* patients including routine bladder and bowel care, wound care including post surgical wound care, pressure ulcers and leg ulcers, LTC management, IV and controlled drug administration. Provide support for families and carers alongside formal care workers to maintain independence and unnecessary prevent hospital admission.

To provide specialist clinics for leg ulcer care for ambulatory and non ambulatory patients (exact cohort to be defined).

Supported by specialist input from other community services (e.g. bowel and bladder services and tissue viability) as required

On the assumption that national funding is agreed ; to provide vaccinations to 'housebound patients and those living in a care homes

Capabilities required

Leg and Pressure Ulcer Care, Wound care, PEG and NG management. Phlebotomy, Palliative care, syringe drivers, Catheterisation, give IV antibiotics, administer controlled drugs, skill mix needs development with NMPs and ACPs to provide accountability & continuity 24/7

Who the care function is for

Over 18 housebound patients and ambulatory patients with leg ulcers (cohort to be defined)

How the function is accessed

Primary care referrals, referrals from other community services, referrals from intermediate care via integrated discharge team.

Linked into central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user's home Including Care Homes and in hostels and other homeless accommodation. Leg Ulcer Clinics	24/7 Ambulatory Leg Ulcer Clinics 9-5 Mon - Fri	Within 48 hours prioritised on need	As by clinical assessment and care plan

Integration with wider health and care system

Aligned to geographical localities. Work alongside primary care and practice/PCN extended roles with expectation of named point of contact in team for each GP practice.

Close working relationship with specialist nursing, palliative care and other community health services, community beds, adult social care and community Mental Health Services as well as the voluntary sector.

Work closely with acute services in particular, elderly care wards.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Enhanced health in care homes (EHCH)

Overview

Description of the care function

- Community service contribution to EHCH requirements as per national specification and NCL May'20 model of care
- The focus is on anticipatory and proactive care provision to prevent acute deteriorations
- When residents are deteriorating the team is able to quickly assess these patients and provide appropriate support to avoid them requiring hospital admission
- When residents do require hospital admission, the EHCH team works with the IDT, intermediate care and the care home to support speedy discharge back to their place of residence
- Support for holistic end of life care for care home residents
- Support care home staff through training and specialist advice

Capabilities required

Community nursing (including providing trusted assessment, enhanced wound care and tissue viability), PT and OT input, end of life care input, geriatrician and psychiatry input

Who the care function is for

CQC registered Care home residents

This includes working age adults with learning disabilities, mental health conditions an/or substance misuse

How the function is accessed

Care homes each have a dedicated EHCH team which includes community health staff in MDT. Care home residents are proactively reviewed

Operations

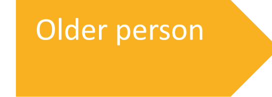
Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In CQC Registered Care homes	Core offer Mon-Sun 8- 8 (with flexibility). 24/7 out of hours provision including therapies to be provided by Rapid Response if required.	On-call geriatrician Within 7 days of discharge/ admission for proactive care	As clinically required

Integration with wider health and care system

EHCH for each care home is led by the local primary care network (PCN) with contribution from community nursing and therapies to the MDT with named nursing and therapy clinical leads for each care home.

EHCH Teams works closely with wider community and mental health services including LD, rapid response, IDT and intermediate care, core and specialist mental health teams (including dementia and memory loss) and adult social care.

Draft specifications



Contains national requirement targets

Core offer care function: Equipment, wheelchairs and orthotics

Overview

Description of the care function

Community Equipment covers a range of items that are provided in people's homes to support independence. It includes commodes, hoists, grab rails and other items.

The service does not have hours of operation, but is rather contracted to deliver equipment within specified timeframes, e.g. 1-7 days, depending on the urgency of the request.

Wheelchair

Clinic and home assessments of CYP and adults with ongoing disabilities.

Equipment and Orthotics

Functional assessment of CYP and adult with short term and ongoing disabilities. Assessment and provision of equipment and wheelchairs and implementation of required home adaptations. Support and training to use equipment. Regular review of changing needs. Includes orthotic assessment of CYP and adults with disability and provision of appropriate orthoses

Capabilities required

OTs, physiotherapists, rehab engineers, rehab/therapy assistants, orthotists, podiatrists and prosthetists

Who the care function is for

CYP and adults with disability

How the function is accessed

Community health services, social care practitioners, education facilities rehab facilities, care homes and supported environments, acutes and primary care can access service for patients

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community, clinic and care homes. Able to deliver to patient homes	**Urgent Equipment** 7 day service **Wheelchair and orthotics** 9-5 Mon-Fri out of hours emergency repair service 7 days	Same day for urgent referrals (excluding orthotics) Rest dependent on service and level of need	Reflecting individual pathways and care plans

Integration with wider health and care system

Works alongside all community, acute, social care VCS and primary care services. Also links to IDTs, rapid discharge and palliative care services

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Community health support Long Term Condition management (general requirements for LTCs)

Overview

Description of the care function

Expectation that Long term care management is mostly led by primary care. Specialist community care LTC services supports those patients with complex needs:

- Provide advice and guidance to primary care and other services
- Provide specialist holistic assessment and support care planning
- Provide specialist therapeutic support when required
- Facilitate specialist structured education and self management programmes, peer support programmes and psychoeducation to support patients/families/carers to be more empowered in their own health management / health outcomes, including psychology and counselling input where needed
- Maximise delivery of care to patients home through remote monitoring

PIFU: Patient initiated follow-up (PIFU) is giving patients and their carers the flexibility to arrange their follow-up appointments as and when they need them. PIFU can be used with patients with long or short-term conditions and following treatment or surgery. Patients get care and support when they need it, whilst avoiding unnecessary trips to hospitals and clinics, saving them time, money and stress.

Capabilities required

Specialist competencies for each long term condition. Psychology and occupational therapy in each team. Trained to deliver self management programmes, physiotherapy where appropriate

Who the care function is for

Patients with long term conditions. Support is both for patients and for the primary care professionals specifically looking after them

How the function is accessed

Primary care and district nurse referral. Referral from acute services

Self referral and patient initiated follow up are vital

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri for routine support with flexibility; out of hours provided by district nursing and 111	2 weeks	2 weeks for follow up or as clinically required Patient initiated follow up

Integration with wider health and care system

Provide specialist advice and input to primary care without a formal referral being required.

Provide advice, training and support to district nursing and acute services.

Closer working relationship with equipment, orthotics and dietetics as required.

Contribute to complex care and frailty MDTs as required.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Diabetes (LTC management)

Overview

Description of the care function

Specialist community diabetic support for adult patients which enables development of enhanced self care and management. Includes 1-1 clinic appointments, home visits and group education sessions.

Support the use of technology to help patients manage their condition

Capabilities required

Specialist diabetic and podiatry nurse competencies, clinical psychology input who can carry out assessments and deliver short term psychoeducation; delivery of DESMOND

Who the care function is for

Adults diagnosed with Type 1 and 2 diabetes who require support beyond that provided by primary care

How the function is accessed

Via primary care (via central point of access) and diabetic clinic. Patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri. with some flexibility to meet needs of patients and families	Same day for advice to primary care; two weeks for initial patient contact	Four week follow up Patient initiated follow up

Integration with wider health and care system

Integrated with acute diabetic clinics; available for advice and support to primary care, community nursing, other community health services. Contributes when required to complex care MDTs

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Musculoskeletal (LTC management)

Overview

Description of the care function

Assessment of treatment of a range of musculoskeletal disorders. Includes both urgent and routine provision. Includes specialist MDT support for complex musculoskeletal disorders. Work with podiatry as necessary
Enhanced clinical triage to minimize inappropriate referral into secondary care MSK services
Includes specialist MDT support for complex musculoskeletal disorders e.g. Spinal, Rheumatology and Pain
Support the use of technology to help patients manage their condition and support the use of technology to help patients manage their condition

Capabilities required	Who the care function is for	How the function is accessed
Specialist musculoskeletal physiotherapists and MSK Advance Practice Physiotherapists; clinical psychology input for MSK Pain Management Programme *(NICE requirement)*	Adults with musculoskeletal disorders	Via primary care and and acute MSK clinics. Patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	8-6 Mon-Fri with some flexibility;	Same day for advice to primary care; 2 weeks for initial contact for urgent. 6 weeks for routine	As clinically indicated Patient initiated follow up

Integration with wider health and care system

- Works closely with all secondary care MSK services incl pain management, Orthopaedics and Rheumatology
- Enhanced clinical triage to minimize inappropriate referral into secondary care MSK services
- Links to falls service
- Provides advice and support and works with podiatry services
- Promotes self care for MSK disorders
- Appropriate use of diagnostic testing eg MRI , blood tests for MSK disorders

Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: Heart failure and cardiac rehabilitation (LTC management)

Overview

Description of the care function

Provision of short term rehabilitation support and education to patients recovering from heart attacks and cardiac surgery.

Support for chronic management of heart failure. This includes support to self manage, anticipatory care planning and support for families and carers.

Includes mental health assessment and support for heart failure patients

Provide advice and education to other community health services and primary care

Capabilities required

Cardiac nurse specialist

Physio

Clinical psychologist

Who the care function is for

Adults who have suffered acute myocardial event and those with heart failure

How the function is accessed

Via acute services, via primary care and district nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Acute wards, service users' Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri with some flexibility to meet needs of patients and carers	Meet national target that 85% of eligible patients received support 2 day response	Up to daily review as required to support cardiac rehab in the community; Patient initiated follow up

Integration with wider health and care system

Daily working relationship with acute inpatient wards and cardiology outpatients.

Work alongside community nursing, rapid response and intermediate care. Work closely alongside palliative care and are involved in anticipatory care planning

Provide advice and support to primary care

Contribute to complex care MDT discussions

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Respiratory service (LTC management)

Overview

Description of the care function

Provision of specialist support, education, co-ordination of care and treatment to optimise quality of life and functioning for adults with chronic respiratory disease and to promote self management.

Support for respiratory rehabilitation.

Provision of spirometry and lung function tests.

Home oxygen service.

Support the use of technology to help patients manage their condition

Capabilities required

Respiratory nurse specialist

Physio

Clinical psychologist

Respiratory physiologist

Who the care function is for

Adults with COPD, asthma and other chronic respiratory conditions where there is functional impairment

How the function is accessed

Via acute services, via primary care (via central point of access) and community nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Acute wards, service users' Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri with some flexibility to meet needs of patients and carers	2 weeks for urgent referrals 4 weeks for non urgent spirometry	Up to weekly review as required Patient initiated follow up

Integration with wider health and care system

Daily working relationship with acute inpatient wards and respiratory outpatients.

Work alongside district nursing, rapid response and intermediate care

Provide advice and support to primary care

Work closely alongside palliative care and are involved in anticipatory care planning

Contribute to complex care MDT discussions

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Post-Covid (LTC management)

Overview

Description of the care function

Unique integrated rehabilitation pathway for individuals with post-COVID 19 syndrome (aligned to NHS England five-point plan, national guidance April'21). Service delivers comprehensive medical assessment and rehabilitation interventions for patients in the community. The service consists of a specialist MDT, community nursing and supports development of self-management.

The team treats not only individuals discharged from hospital but also those in the community who did not require inpatient care. Support the use of technology to help patients manage their condition

Capabilities required

Online resources for self management, MDT consisting of PTs, OTs (including neuro OTs), specialist consultants as required, respiratory nurses and dieticians

Who the care function is for

Adults with a set of persistent physical, cognitive and/or psychological symptoms that continue for over 12 weeks after COVID and are not explained by an alternative diagnosis.

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, service users' own home, place of work/study, face to face and virtual	9-5pm Mon-Fri with some flexibility of hours	1 week	As clinically required Patient initiated follow up

Integration with wider health and care system

Team works alongside wider professional network to support service users and their families / carers including social care, acute and primary care as well as any other specialist services (e.g. Respiratory LTC service).

Service works closely with IAPT offers including an IAPT presence at every specialist MDT to triage patients and offer advice and assessment.

NCL has a system wide vocational rehabilitation offer provided by the RFH specialist team.

CYP | Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: MDT for complex needs – Anticipatory care (read in conjunction with Frailty; EoLC)

Overview

Description of the care function

Locality based MDT that specifically manages identified cases with complex needs cases and bridges physical, mental health, dementia, end of life, housing and social care needs. This is a multi-professional and multi-agency team that holds the most complex individuals. The team agree care and support plans and meet daily (can meet virtually) to discuss specific cases. Team able to use technology to support virtual MDT's and ensure availability of shared records.

The team complete a care needs assessment and care and support plans and meet regularly (can meet virtually) to discuss specific cases.

Each complex needs case should have case management and coordination to ensure the individual has access to the right services.

Capabilities required

MDT of professionals from MH, CH, social care and acute services as required

Who the care function is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, dementia, disability

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

Integrated care partnership will be key to ensure a single borough plan and to enable delivery.

This is an integrated multi-agency service from across MH, CH, social care and acute services.

Should link in with primary care, VCS, police and other services as required (for example housing and safeguarding).

Working age adult

Older person

Contains national requirement targets

Draft specifications

Core offer care function: Community phlebotomy

Overview

Description of the care function

Provision of phlebotomy service for housebound patients for diagnostic testing and monitoring purposes

Additionally, provision of phlebotomy service to support other community health care functions including rapid response and intermediate care

Capabilities required

Phlebotomists

Who the care function is for

Housebound patients

Patients under care of other care functions of community health offer

How the function is accessed

Accessible from primary care, other community health services and has regular sessions on community bedded wards. Integrated part of enhanced health in care homes team

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Patients' homes, care homes	9-5 Mon-Sun with some flexibility to meet service and patient needs	Same day availability	N/a

Integration with wider health and care system

Integrates with other care functions of community health offer; works alongside primary care with identified contact for each PCN and for each enhanced health in care homes team

Key care function of intermediate care teams and rapid response

It is anticipated that phlebotomy for care home patients will be provided by trained care home staff.

Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: Podiatry

Overview

Description of the care function

The podiatry service provides assessment, diagnosis, advice, treatment and referral for a wide range of foot conditions although the expectation is that most patients will have high risk Type 1 diabetes. Nail cutting is only provided for patients with high risk foot conditions (eg sensation loss and reduced circulation

Supports individuals with compromised tissue viability associated with vascular disorders, diabetes and other underlying medical conditions that affect their feet, and support wound management.

Works closely as part of the Diabetes team given interface with management of diabetic patients.

Service users and their families and carers trained and supported to actively participate in the management of their condition.

Capabilities required	Who the care function is for	How the function is accessed
Podiatrists and foot care assistants	Adults requiring assessment, treatment and advice on foot conditions.	Referral through central point of access by GP or other health professional. Can also be through self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics or in service user's home if house-bound	9-5 Mon-Fri with some flexibility	New patients within 4 weeks Urgent referrals within 1 week	As required up to twice weekly review

Integration with wider health and care system

Provide expert advice and support to primary care, community nurses, and other specialist services including diabetes, MSK and AHPs.

Integration with orthotics services.

Direct referral for podiatric surgery as required

Support acute hospitals with ward in-reach for high risk podiatry referrals

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Bladder and bowel and continence services

Overview

Description of the care function

Range of advice and support to help people self-manage complex continence issues and remain independent.

Support when necessary to adapt and modify their lifestyles to adjust to increasing dependence.

Provide advice, guidance and training to community nurses and primary care. Provide support and education to families, carers and nursing home staff.

Continence Nurse specialists can be contacted directly by patients for ongoing advice/support.

Capabilities required

Continence nurse specialists

Catheterisation

MDT as required with continence nurses, nephrologist, urologists, gastroenterologist etc.

Who the care function is for

Adults with complex continence issues who need additional support beyond that provided by community nurses

How the function is accessed

Can be contacted for support by community nurses, intermediate care, primary care and EHCH team as well as self-referrals; via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, telephone advice, patients homes and nursing homes	9-5 Mon-Fri with some flexibility	1 week for urgent 6 weeks if routine	As required up to twice weekly review or as clinically required

Integration with wider health and care system

Provided expert advice and support to primary care, community nurses, intermediate care team and enhanced health in nursing homes team

Provides advice and support when required to reablement and other social care teams

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Neurology community services

Overview

Description of the care function

Specialist holistic community support for patients with chronic and acute on chronic onset neurological conditions. This includes multiple sclerosis, Parkinson's disease and epilepsy. Provision of evidence based interventions to support self care and management, improve functioning, support vocational rehabilitation and improve emotional wellbeing. Includes support for families and their carers.

Works alongside primary care, district nursing and community rehabilitation and where necessary brings in other community health expertise

Facilitates expert patient programmes and peer support groups

Capabilities required

Nurse specialists

Occupational and Physiotherapists

Clinical psychologist

Who the care function is for

Adults with active onset neurological conditions

How the function is accessed

Via primary care (via central point of access) and neurology clinic

Utilises patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic face to face, telephone / virtual support; in patients home where necessary	9-5 Mon-Fri with some flexibility around patients needs	1 week for initial urgent reviews; otherwise 4 weeks	As required but up to weekly review

Integration with wider health and care system

Works closely with Community Rehabilitation Services, community nursing and primary care

Contribute to complex care MDTs as required and provide assessments to support social care reviews as required

PCS services will review on for specialist input from neurological teams when required.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Please note: this draft spec is under review.

Core offer care function: Lymphoedema

Overview

Description of the care function

Assessment and treatment of patients with lymphoedema whether this is the primary problem of related to underlying cancer, infection or other cause

Support and education for patients and their carers to support self management of their condition.

Advice and support for other healthcare professionals and care home staff on how to manage and support patients with lymphoedema

Capabilities required

Lymphoedema nurse specialists

Who the care function is for

Patients with primary or secondary lymphoedema

How the function is accessed

Via acute services, district nursing or primary care

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In hospital clinics and on wards; remotely via phone; in patients homes as required	Mon-Fri 9-5 with some flexibility to meet needs of patients and their families	Palliative: 10 days Cancer: 6 weeks Non-cancer: 8 weeks	As required but up to daily review

Integration with wider health and care system

Advise and support community nursing nursing, intermediate care teams, palliative care and primary care as required. Input to enhanced health in care home teams as required. Work closely alongside tissue viability service

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Pain management

Overview

Description of the care function

AHP-led multidisciplinary service. Advice provided by both acute and community clinicians, offering guidance and treatment for patients with persistent pain in the community. The service conducts assessments of a patient and co-produces a pain management plan. This could include the provision of medical interventions e.g. spinal injections, exercise and psychological interventions. Where possible, the service empowers patients to self manage their pain.

Capabilities required

Pain consultant competencies, advanced Physiotherapy pain specialists and clinical psychologists, substance misuse nurses, physiotherapists, pharmacists and IAPT practitioners

Who the care function is for

Patients with persistent or recurrent pain not adequately managed in primary care with significant distress or functional impairment

How the function is accessed

Primary care, LTC services and acute services, including MH services, can engage service for advice and support and can refer patients for review

Patient initiated follow up as appropriate.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Telephone/ virtual advice and support, community clinic, MH ward reviews.	9-5 Mon-Fri with some flexibility.	Within a week for most urgent; otherwise 1 month	Routine or regular review within 2 months and/or patient initiated follow-up as appropriate

Integration with wider health and care system

Advises and supports primary care to prevent need for referral to specialist pain management services. Also advises and supports other community teams, such as long term condition services.

Contributes to MDT with Pain Management consultants in secondary care and to complex care MDTs as required.

Also offers advice and support to clinicians in other acute specialties and on inpatient MH wards.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Tissue viability and wound management

Overview

Description of the care function

Provide specialist advice and support to health care professionals on the management of patients who are at risk of developing or have chronic wounds, including assessment, developing a management plan and delivering first treatment if necessary.

Chronic wounds may include post surgical wounds, leg ulcers and pressure ulcers. Provide specialist advice for the management of wounds associated with diabetes and/or vascular disease.

Provide specialist advice on the management of complex wounds and specialist clinics for complex ambulant patients.

Provide education and training for staff in the community and mental health trusts, practice nurses, nursing homes staff and carers.

Provision of advanced wound care treatment such as debridement and negative pressure in the community reducing unnecessary hospital admission.

Capabilities required

Assessment, first treatment if needed and care plan for complex wounds. Utilisation of specialist dressing and treatments, Training to other professionals.

Who the care function is for

Adults with complex wounds who live at home or homeless accommodation (including rough sleepers), live in care homes or are in-patients in a Mental Health ward or community beds.

How the function is accessed

Primary Care, other CH services, end of life care and acute services, including MH, can ask for advice & guidance and assessment, a management plan and direct highly specialised care from a TV nurse.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Remote advice and guidance; patients' homes, including care homes MH wards, GP practices or other settings e.g. homeless hostels	9-5 Mon-Fri with some flexibility	1 day for urgent reviews	As per clinical assessment

Integration with wider health and care system

Provide advice, support and guidance to community nurses, primary care, physical and mental health acute ward teams, extended PCN roles, diabetic specialist nurses, nutrition and dietetics teams.

There will be a clear pathway to and from Tissue viability services for patients with chronic wounds. Clinical staff with responsibility for ongoing management of the patient's wound will be supported to develop the appropriate competencies and skills level.

There will be clarity about levels of specialism, skills and responsibility expected across the system, including for TV nurses, for delivering wound care management

Link in with equipment and wheelchair team, and podiatry teams as required.

Working age adult

Older person

Contains national requirement targets

Draft specifications

Core offer care function: Integrated discharge Team (IDT)

Overview

Description of the care function

The community component of the Integrated Discharge Team provides the operational leadership for the IDT and a proportion of the case managers. The role of the team is to be fully integrated with the hospital discharge team enabling:

Early identification of people at risk of discharge delay

Case management to mitigate those risks

Same Day Discharge

Home First Ethos

Case Management post discharge to optimise recovery and independence

Capabilities required

Proactive case manager

Who the care function is for

Adults requiring support to enable them to be discharged home (P1), to recovery/rehab beds (P2) or to long term residential care (P3)

How the function is accessed

Hospital staff identifying that someone is a risk for discharge.

Hospital staff completing NCL Discharge Referral Form within 1-2 hours of becoming Medically optimised

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Whilst people are in hospital At the point of discharge At home until Care Act/CHC Assessment completed	Mon-Sat 08:00-18:00 Sun 08:00-13:00 Ability to flex up to max 08:00-20:00	Daily review of patients who are clinically safe to discharge at ward board round	P1 Assessment same/next day P2 participating in discharge planning from unit

Integration with wider health and care system

Daily working relationship Acute Complex discharge team, D2A resources, CHC, LA brokerage, VCS,

Close working relationship with other IDTs, housing, homeless services, equipment services

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for local residents

Daily working relationship Acute Complex discharge team, D2A resources, CHC, LA brokerage, CIC VCS. This includes complex pathways such as delirium, braces and NWB, which are under review across NCL for alignment.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Rapid response/Urgent Response

Overview

Description of the care function

Rapid holistic assessment of patients experiencing a deterioration of health and wellbeing and at risk of hospital admission within the next 2-48 hours. The MDT will develop a personalised care plan and provide a seamless offer that typically involves elements such as nursing, emergency care from a paramedic and functional therapeutic support to prevent avoidable admissions. The service will aim to optimise independence and confidence, enable recovery and prevent a decline in functional ability. All services will meet the 'Community health services two-hour crisis response standard guidance' and NICE Guideline NG74.

Capabilities required

GP, geriatrician, nursing, physio, OT, and health and care support staff. Ability to administer IV antibiotics, prescribe, deliver point of care testing and arrange access to packages of care.

Who the care function is for

Adult (+18) resident in NCL (or within a mile with NCL GP) experiencing a crisis (sudden deterioration in a person's health and wellbeing) and **at risk of hospital admission** within the following 2-to-48-hour period. The adult does not have to be housebound to be eligible.

How the function is accessed

Via a single point of access with referrals from GPs, NHS 111, A&E/SDEC, frailty units, ambulance services, self-referral, carer referral or care homes.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Usual place of residents (home or care home)	24/7 7 days a week by 2024 for 2hr UCR response	2 hour for urgent needs; up to 1 day for non urgent.	Daily MDT case discussion and in person or virtual patient review. Short-term intervention based on the treatment plan.

Integration with wider health and care system

Full alignment with:

- Access to range of community services available in the borough
- Unplanned care programmes eg. NHS111, UTCs, Same Day Emergency Care and 999 Crisis response care
- Primary care such as GP out of hours, GPs and PCNs.
- IDT

Closer relationship with services that will be required to provide ongoing support for patients including adult and older adult mental health services, proactive care services, community nursing teams, core and specialist community services, social care* and reablement services.

**Close working with adult social care partners to ensure an aligned and integrated seamless care for resident.*

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Discharge to Assess Pathway 1

Overview

Description of the care function

Delivery of immediate support following discharge on day medically optimized

Provides a holistic assessment of need and determines the appropriate level of recovery or reablement care required to support someone safely at home.

Ensures appropriate equipment is in place and safe to use

Resolves any issues that emerge once home

Tweaks care plan and equipment over time to fit level of need

Identifies point where patient has recovered from hospital stay and is ready to be assessed for long term care if required

Capabilities required

Occupational therapists
Physiotherapists
Pharmacy assistant
Rehabilitation Assistants
Social Care Practitioners*
Reablement providers*

Who the care function is for

People discharged from hospital who need support to be able to manage at home

How the function is accessed

Integrated Discharge Team will make referral to the SPA

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Patients' homes	8am-8pm 7 days a week	High risk within 2 hours of discharge Low risk- next day	Daily contact, often by telephone to monitor levels of care required

Integration with wider health and care system

Daily working relationship IDTs and wards, LA brokerage, VCS,

Close working relationship with other IDTs, housing, homeless services, equipment services

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for local residents

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Community rehabilitation

Overview

Description of the care function

Intermediate, 6 weeks home-based care to improve or maintain independence. Provided consistently across NCL. This includes:

- To avoid hospital admission
- To continue rehabilitation after D2A P1 completed if required
- To enable a multidisciplinary approach to recovery, reablement or rehabilitation to enable optimal physical health and wellbeing (risk of admission not required)

Capabilities required

Community AHP including: Physiotherapy, OT, SLT, dieticians, podiatry. Clinical psychology, Social Care Practitioners*, Community Nursing, Pharmacists

Who the care function is for

Adults requiring home based prevention, rehabilitation, and care plans to optimise health and wellbeing. Consistent thresholds across NCL for P2 step-down

How the function is accessed

Referrals accepted from Pathway 1, primary care, adult social care and community based services

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In patients' homes, place of work/study, remotely or face to face	08.00-18.00 with some flexibility 7 days/week	2 days, where appropriate	Defined by individual care plan

Integration with wider health and care system

Daily working relationship with reablement services, Integrated discharge teams (IDT), community nursing, primary care and acute care, rehabilitation facilities, neuro-navigators, frailty leads and PCNs . Contributes to broader MDT discussions

Close working relationship with rapid response/IDT teams regarding assessment of patients and appropriate handover.

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for residents

Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: Neuro and stroke community rehabilitation

Overview

Description of the care function

Intermediate 12 week home-based care to improve or maintain independence. Provided consistently across NCL. This includes:

- To avoid hospital admission
- To provide Early Supported Discharge for Stroke
- To enable a multidisciplinary approach to neuro rehabilitation to enable optimal physical health and wellbeing (risk of admission not required)

Includes neurological conditions and stroke (e.g. MND, MS, PD, Huntington's, TBI) which meet national stroke standard requirements. This includes vocational rehabilitation.

Capabilities required

Community AHP including: Physiotherapy, OT, SLT, Clinical psychology, Social Care Practitioners*

Who the care function is for

Adults requiring home based rehabilitation, and care plans to optimise health and wellbeing. Consistent thresholds across NCL for P2 step-down

How the function is accessed

Referrals accepted from HASU, acute hospitals, neurorehabilitation facilities, primary care, adult social care and community based services

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In patients' homes, place of work/study, remotely or face to face	08.00-18.00 with some flexibility 7 days/week	ESD same day discharge Urgent 1 week Routine 4 weeks	Defined by individual care plan

Integration with wider health and care system

Daily working relationship with reablement services, Integrated discharge teams (IDT), Hyper acute stroke units, community nursing, primary care and acute care, rehabilitation facilities, neuro-navigators, Community Neurological services, Palliative Care Services and PCNs . Contributes to MDT discussions

Close working relationship with HASU and rehabilitation units to ensure rapid handover and acceptance .

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for residents

Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: Bedded intermediate care incl stroke and neuro rehab (P2)

Overview

Description of the care function

Intermediate community based bedded care for up to 6 weeks to avoid hospital admission or to facilitate rehabilitation after discharge Includes specialist neuro and stroke rehabilitation beds.
Offers holistic specialist multidisciplinary assessments, evidence based interventions and supports homefirst approach. Incorporates self management approach early within rehabilitation pathway.
Provides specialist signposting for patients with ongoing rehabilitation and disability management needs. Ensures patients have a Joint Care Plan at point of discharge.

Capabilities required

MDT - clinical frailty consultant, stroke and neuro consultants, geriatricians, psychology, rehabilitaion nurses, pharmacy, dietitian, SLT, physio, OT and activity coordinator Rehabilitation competencies including neuro rehab; ability to assess acutely deteriorating patient

Who the care function is for

Adults requiring bedded rehabilitation support to avoid hospital admission or to enable subsequent safe discharge with onward appropriate package of care where needed

How the function is accessed

Via Integrated Discharge Team; Rapid response team can also refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community bedded wards	24/7 nursing care with rehab therapeutic input 9-5 7 days/week	Same day response	Therapeutic rehab input up to twice daily/ 7 days/ week

Integration with wider health and care system

Daily working relationship with Reablement services, Integrated Discharge Teams (IDT), Community Nursing, non-bedded P1 Rehab Teams, Primary Care and Acute Care. Contributes to broader MDT discussions. Daily working relationship with residential transition and short term care beds as well as local care homes via enhanced health in care home teams (P3)

Close working relationship with Rapid Response team regarding assessment of patients and appropriate handover.

Close working with IDTS, care navigators, Specialist Nurses and AHP.

Mental health in-reach from MH teams – integration with MH core offer. Close working with Level 1 neuro rehab beds and other bedded care.

Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: End of life and hospice care

Overview

Description of the care function

- Symptom management support, holistic support, pre and post bereavement support, anticipatory care planning, support for loved ones & carers
- Provision of hospice at home care which involves MDT provision of care within patient's home including support for family and carers
- Bedded hospice care provides intensive symptomatic support and terminal care to patients and their loved ones on palliative care pathways. This included provision of respite care

Capabilities required

Can administer IVs and prescribe controlled drugs, set up syringe drivers; palliative care consultant supervision, therapy, psychology and social worker input

Who the care function is for

Over 18s and loved ones when patient has life limiting illness or is at the end of their lives

How the function is accessed

Primary care, community nurses and acute inpatient and outpatient services can phone for advice and support and to make referrals

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Patients homes, hospices, support on acute and community wards	8am-8pm 7 days/week for advice and visiting. Out of hours provision 8pm-8am Hospice beds 24/7	Six hour response for urgent referrals, 7 day non urgent	2 hour response for urgent escalations

Integration with wider health and care system

Available for advice, support and provision of training to primary care, community nurses, acute services and care homes

Dedicated palliative care team for each borough with clear links to each PCN in the borough.

Anticipatory care planning done jointly with primary care

Close relationships with non NHS funded hospice and community end of life care

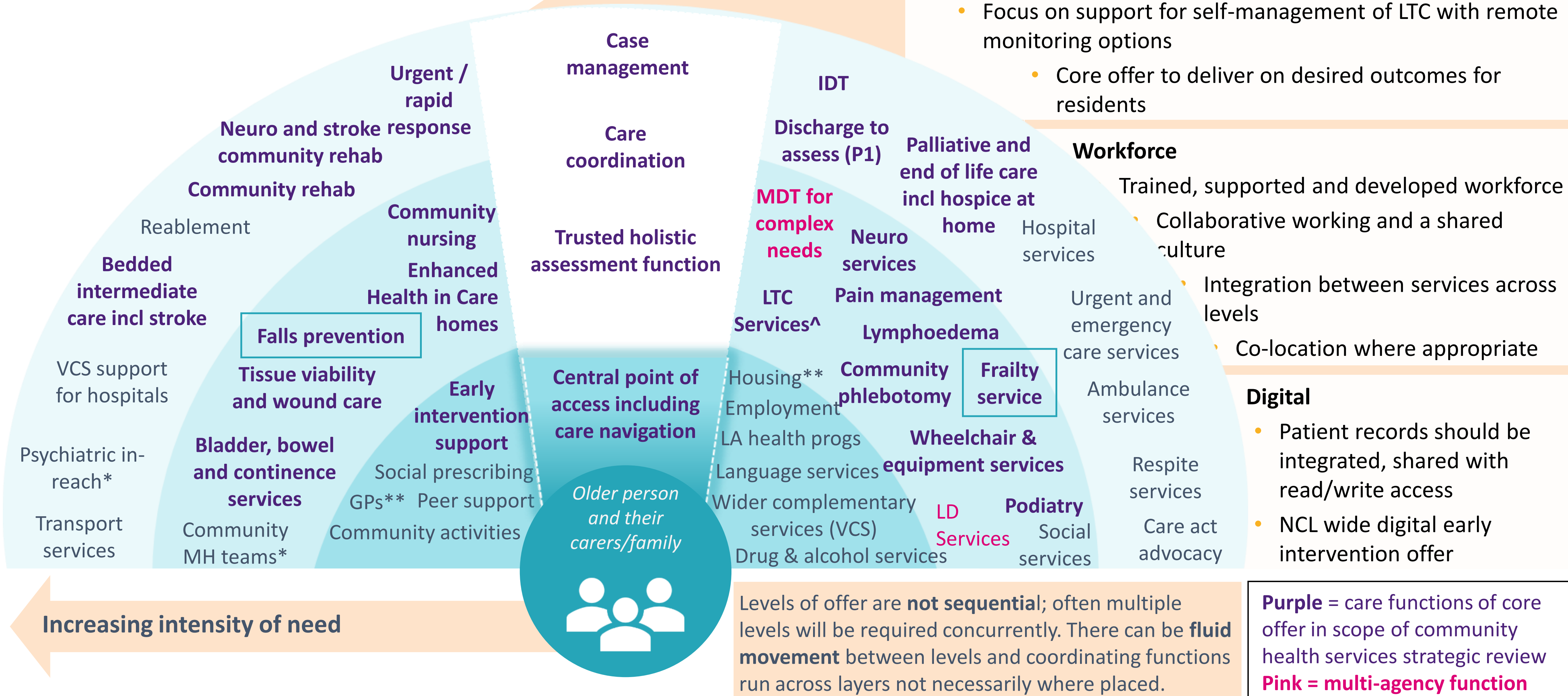
Close working relationships with equipment services and pharmacies. Need to have access to input from therapies

Every GP practice to hold EOLC MDT meetings with palliative care team and community nurses on a quarterly basis

Older people

Draft core offer outline – Older people Community Health

Description of care functions specific to older people follow this slide and are shown in the diagram below in boxes; other care functions are described within the working age adult offer



Care and support to service users and their families / carers

- Shared decision making and care and support planning
- No wrong door for support - Services sensitive to cultural and other demographic factors that impact on how individuals prefer to access care
- Focus on early-intervention and **anticipatory care**
- Clear link between physical and mental health and wellbeing
  - Focus on support for self-management of LTC with remote monitoring options
    - Core offer to deliver on desired outcomes for residents

Workforce

Trained, supported and developed workforce

- Collaborative working and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records should be integrated, shared with read/write access
- NCL wide digital early intervention offer

Levels of offer are **not sequential**; often multiple levels will be required concurrently. There can be **fluid movement** between levels and coordinating functions run across layers not necessarily where placed.

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

^Details for management of specific LTCs are shown in subsequent slides

**Housing including homelessness services
***GPs and broader primary care team including extended roles

Older person

Contains national requirement targets

Draft specifications

Core offer care function: Falls prevention

Overview

Description of the care function

Delivered as a standalone service or in partnership with local agencies, depending on patients' needs & circumstances. Functions include:

- Providing advice, signposting & exercise support for people who need to improve balance, as part of an integrated support network
- Assessment of medical, functional & environmental needs (including bone strength) and preferences - part of a holistic joint assessment with other partners
- Support planning & prescribing of solutions (e.g. equipment) to mitigate risk of falls - part of integrated recovery/LT care plan
- Support patients who have fallen/repeat fallers to recover, rebuild strength, improve balance, confidence and independence
- Provide advice, guidance and training on falls to professionals and others, including as part of integrated MDTs
- Modifiable falls risks have personalised care plan shared across the wider MDT
- Ensure non-modifiable falls risks are mitigated
- Support and empower service users to self-manage
- Able to support those with dementia living at home and at risk

Capabilities required	Who the care function is for	How the function is accessed
Physiotherapy competencies, OT competencies; dietetic input. Capability to work in integrated multi-agency care & support settings	Individuals screened, known or judged to be likely at higher or 'rising' risk of falls, including those with osteoporosis; individuals with history of falls	'Trusted referrer' routes: PC, acutes, social care, other named referrers, including integrated care partners; OR self referral; patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user homes or in local clinics	Mon-Fri 9-5 with some flexibility	1 week for urgent referrals	4 week follow up

Integration with wider health and care system

This is one element of multi-agency network with primary care, NHS Trusts, public health, social care, Councils & VSC to:

- Support community solutions to improve balance for those at risk of falling or as part of an 'Ageing Well'
- Routine multi-agency screening to identify those at risk, and patient management within primary care and PCNs
- Supports those at 'rising risk' of falls in conjunction with others, and those who had a fall or repeat falls
- Specialist secondary medical intervention for those with more complex syncope or who were hospitalised

Works alongside:

- Joint Intermediate care services to support people to recover following crises or hospitalisation, including rapid response.
- Frailty/multi-morbidity MDTs or Enhanced Health in Care Home models as a component of proactive and holistic care planning;
- Primary care, community health, social care & voluntary sector

Draft specifications

Older person

Contains national requirement targets

Core offer care function: Frailty service

Overview

Description of the care function

The aim of the frailty service is to identify people with moderate and severe frailty (any age) with frailty and improve their care by offering targeted support for their physical and mental health needs. The service follows the British Geriatric Society's model of Find, Recognise, Assess, Intervene, Long-term (FRAIL).

A comprehensive clinical assessment is undertaken which includes memory screening, a medications review and a discussion about wishes and preferences for individual's future care. The service identifies priority areas in a frail person for quality improvement and risk areas for reduction.

Joint care plan developed in partnership with those living with frailty

Support the adoption of virtual ward models, adopting digital tools to support effective care delivery of remote care

Capabilities required

Frailty practitioners linked in with consultant geriatricians

Who the care function is for

Individuals screened, known or judged to be frail or at risk of frailty (frailty register)

How the function is accessed

Referrals from GP's, other community services and the local acute hospitals through the central point of access.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user homes	Mon-Fri 9-5 with some flexibility	1 week for urgent referrals	1-6 visits over a period of 4 to 6 weeks depending on need

Integration with wider health and care system

Works alongside:

- Joint Intermediate care services to support people to recover following crises or hospitalisation, including rapid response.
- MDTs for complex needs
- Enhanced Health in Care Home models as a component of proactive and holistic care planning;
- Falls prevention team
- Memory clinic and older people's core mental health teams
- Primary Care, community health, social care & voluntary sector

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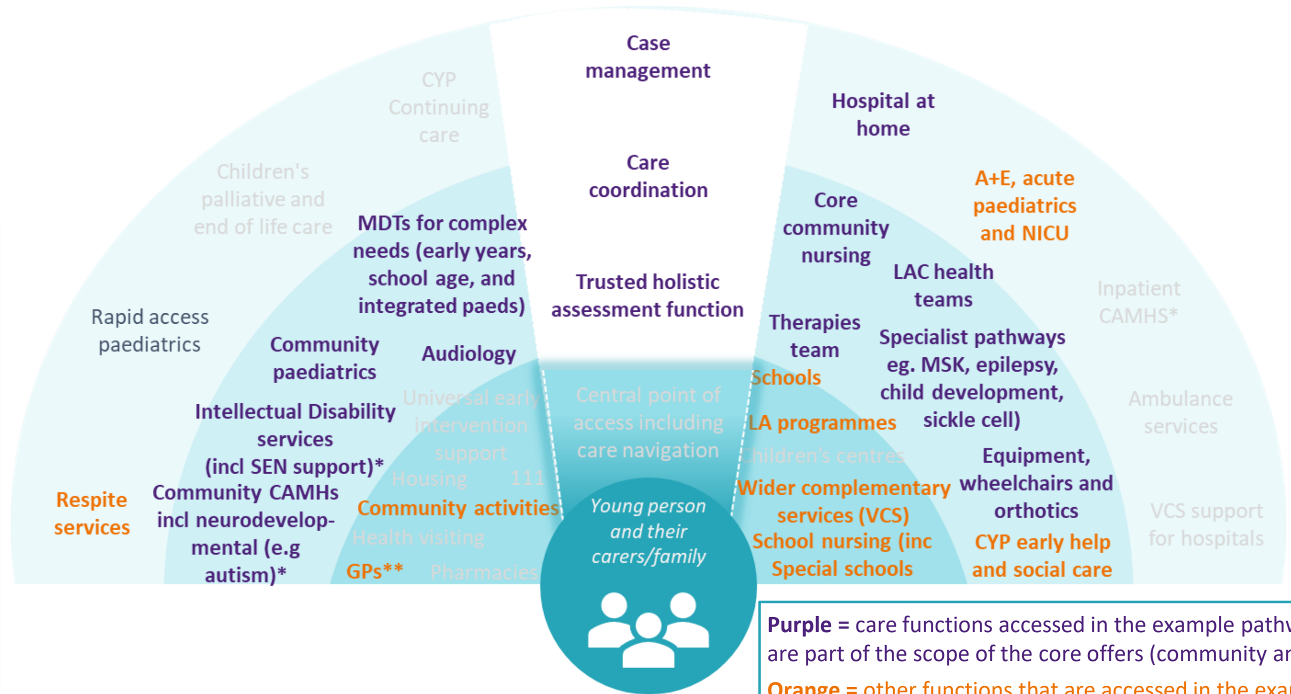
Pen portraits

Increasing holistic needs

Children & Young People	**1. Freya** is a white 14-year-old teenager whose academic performance at school has been deteriorating and appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.	**2. Patrick** is a 7-year-old Black Caribbean boy. He has a diagnosis of autism and also suffers from anxiety. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children. His father has had to give up work to provide the additional support required for Patrick.	**3. Jack** is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family.
Working age adult	**4. Asha** is a British Asian 22-year-old and has suffered from ADHD since primary school. She lives with her family in Archway and is studying economics part-time at London Met university. Her ADHD impacts her performance at university. She has struggled to maintain a job because of her impulsiveness.	**5. Daniel** is a Black 48-year-old man and lives in Tottenham. He suffers from schizophrenia and has been in and out of mental health inpatient facilities including PICU since he was 17. He lives in supported accommodation and is unemployed. His two brothers and mother are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis. He has asthma but does not reliably take his medication.	**6. Melissa** is a 55-year-old Black woman from Kentish Town with poorly controlled Type I diabetes, and chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis. She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She frequently has to have time off work. She lives with her partner.
Older people	**7. Vera** is 70, white, lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions. The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.	**8. Paul** is 72, recently widowed, lives in Edgeware and is Black Caribbean. He has high blood pressure and is now partially sighted. His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost. Paul does not think there is a problem and declines any help.	**9. Yasmiin** is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has mild dementia, breast cancer, heart failure and is thought to be in last 6 months of her life. She has had four hospital admissions in the last six months with breathlessness related to her heart failure.

Example pathway: Child with complex needs

Jack is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family



Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Jack is cared for by an integrated community health team of children's community nurses, a community paediatrician and therapists. He has a case manager who co-ordinates his care and supports the family to navigate his different appointments and wider support available to him. This team regularly reviews Jack's holistic needs getting input via regular MDT from his primary care team, school nurses in his special school, the intellectual disability team and his early help social worker.

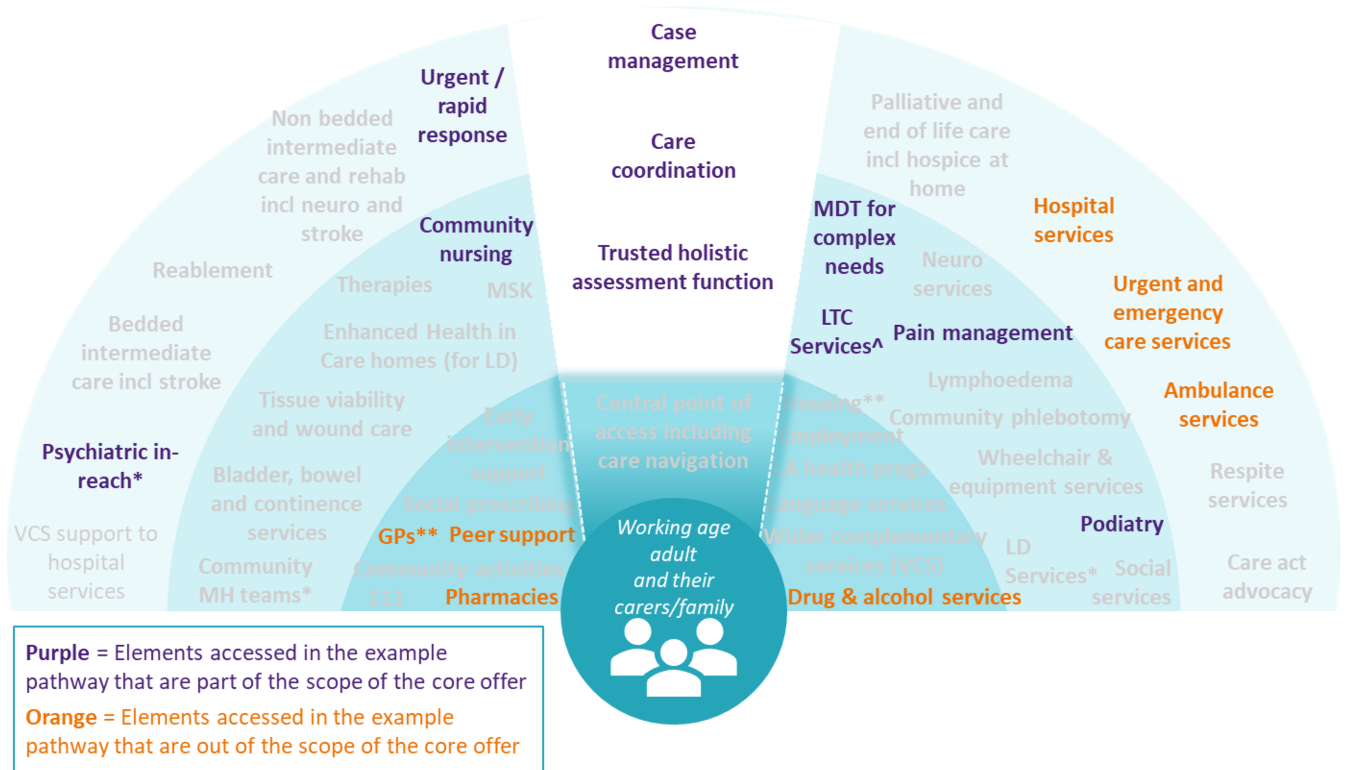
He has regular physiotherapy and the physio also links in with the orthotics and equipment team to provide support. He has regular support from a speech and language therapist for both his swallowing and his speech. A dietician works with him to ensure that his nutrition is maximised and suitable. An occupational therapist works with Jack and his family and teachers to maximise his independence and also his self-esteem. He has a regular medication review with a community paediatrician. The team links in with the NCL audiology team to ensure that Jack is having reviews for his hearing. Jack has a regular review with the learning disability team who contribute to "Team around the child" discussions. Jack and his family have a dedicated early help social worker who provides support regarding school transport, respite care and also regularly reviews if there are any safeguarding concerns at home. Jack has a regular holistic review of his mental health by a clinical psychologist who is attached to the community health team. His mother receives support from primary care and IAPT for her depression and is also supported to attend a peer support group for cerebral palsy carers.

In conjunction with the Hospital at Home team, a crisis plan has been developed which enables Jack to be assessed and cared for at home (when appropriate) as an alternative to hospital admissions when he suffers from episodes of pneumonia. This is supported by same day acute paediatric assessment when required from the Rapid access paediatric service.

Example pathway: Working age adult with multiple and complex Long term conditions

Melissa is a 55 year old Black woman from Kentish Town with poorly controlled Type I diabetes, and chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis.

She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She is a teaching assistant at a local school, but frequently has to have time off work. She lives with her partner.



What care will look like through the core offer

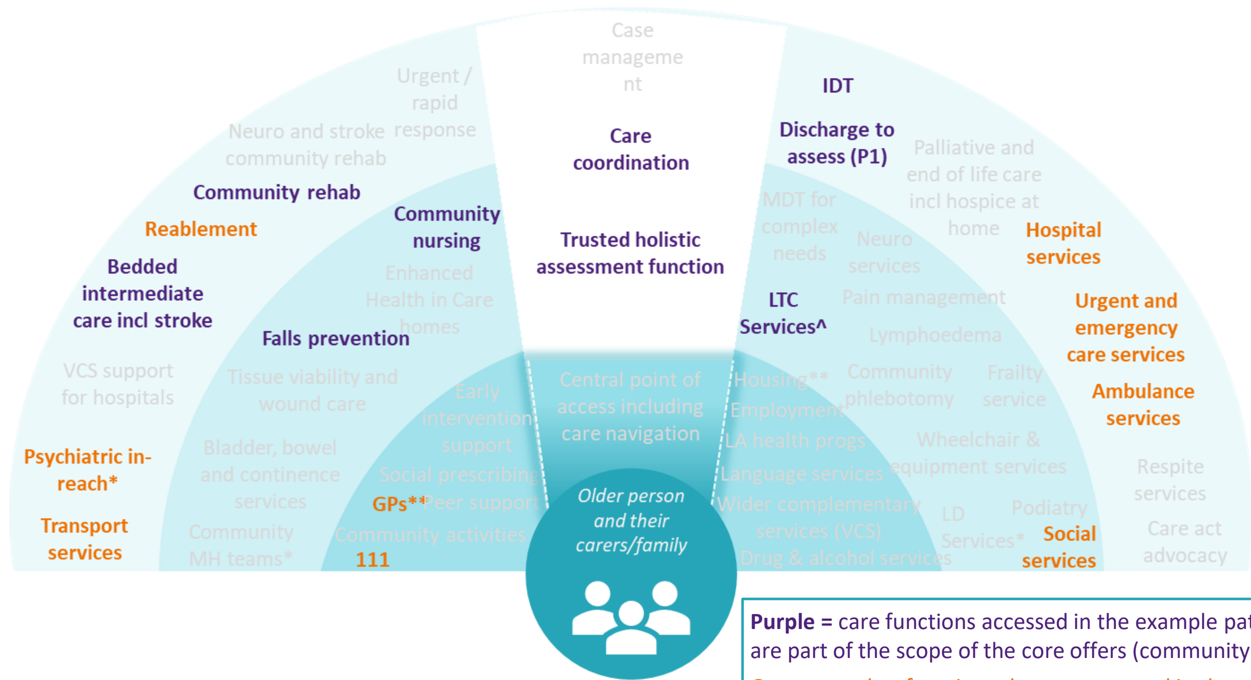
Melissa is supported by the community diabetes team who have carried out a holistic assessment of her needs and preferences. A clinician from the team case manages her care bringing together input from the professionals and services involved in her care. A regular MDT reviews her care utilising the digital health record. In the past Melissa has chosen not to engage with many NHS services and consequently has had very poor diabetic control with severe vascular complications. However, the involvement of a peer support practitioner from Melissa's local community has greatly helped with improving trust and Melissa's blood sugar control has improved. Melissa was also diagnosed with depression by a psychologist in the diabetes team who has been working with the peer support worker to provide support. Melissa has now agreed to start an anti-depressant which has greatly helped her mood. She had been reluctant to attend the pain management service when it was based at the local hospital, but when instead she was offered a consultation based at her GP practice from the pain management specialist this greatly helped. She is now being supported in conjunction with input from the substance misuse local team to withdraw from her opioids and to switch to alternative pain management medication alongside a pain management course

A community nurse visits Melissa twice weekly to change her foot ulcer dressings with advice from the diabetic and podiatry teams. When these ulcers get infected, the rapid response team is able to provide daily assessment and IV antibiotics which has prevented a number of likely hospital admissions.

Example pathway: Older adult with acute and rehabilitation needs

Vera is 70, white, lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions.

The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.



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What care will look like through the core offer

Vera, whilst in hospital, is seen by the psychiatric in-reach team the morning of the referral who confirm via shared care record (which includes primary care) that she has no previous history of mental illness. She is assessed as having delirium and they provide treatment advice to the ward team including regarding adequate pain management. Her delirium settles and she is reviewed by the integrated discharge team (IDT). The team agrees with Vera that she would benefit from a period of intensive rehabilitation in a community rehab bed. This is organised promptly and she is discharged the following day. Whilst in the community rehab bed, she has intense twice daily physio support and a home assessment with an OT early on. The OT links up with the equipment team to arrange required home adjustments. The holistic assessment of the IDT has also identified Vera's loneliness and a social worker is able to support Vera in the rehab bed to review local activities. This includes a tea and chat drop-in at her local church, a peer support group and an arts and crafts group. She also receives a follow-up review by the MH in-reach team who link in via the shared care record with the primary care MH nurse attached to Vera's GP. Vera is subsequently discharged home being seen by a carer to support her with her activities of daily living and by a community nurse alternate days to review her wound. She continues to be seen 2x weekly at home by the physio and OT from the non bedded rehab team. They organise for her to be assessed by the falls prevention team who arrange diagnostic tests to rule out likely causes of falls. After two weeks of non-bedded rehab, Vera is discharged back to primary care management with a full written handover on the shared care record and continued input from the falls prevention team.

Example pathway: Older adult with likely dementia

Paul is 72, recently widowed, lives in Edgware and is Black Caribbean. He has high blood pressure and now partially sighted.

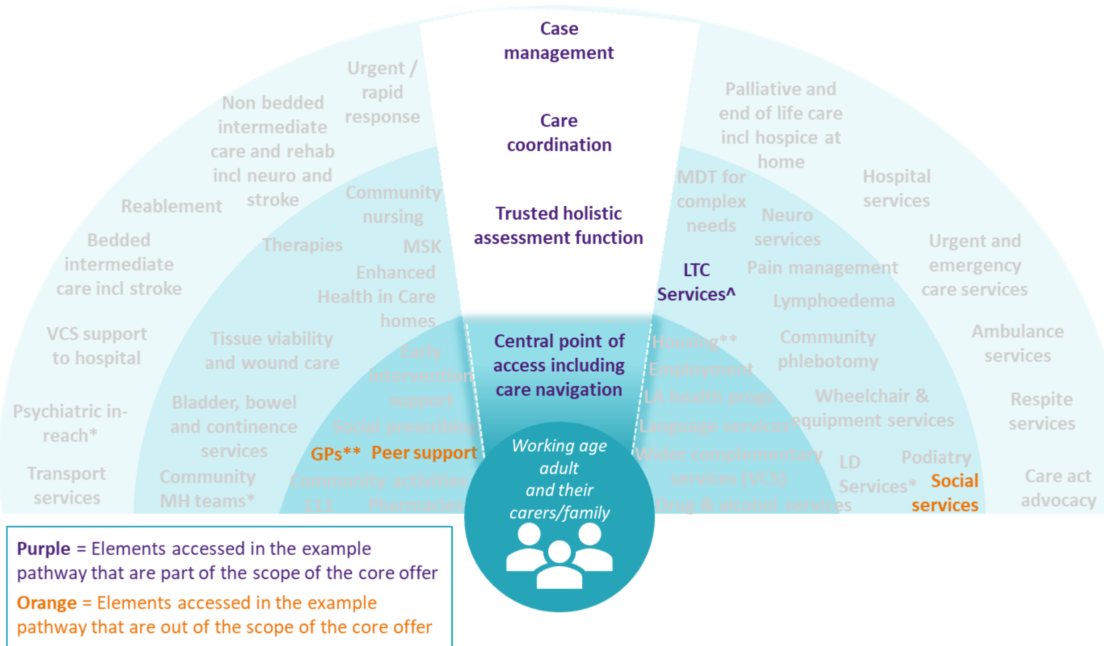
His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost.

Paul does not think there is a problem and declines any help.

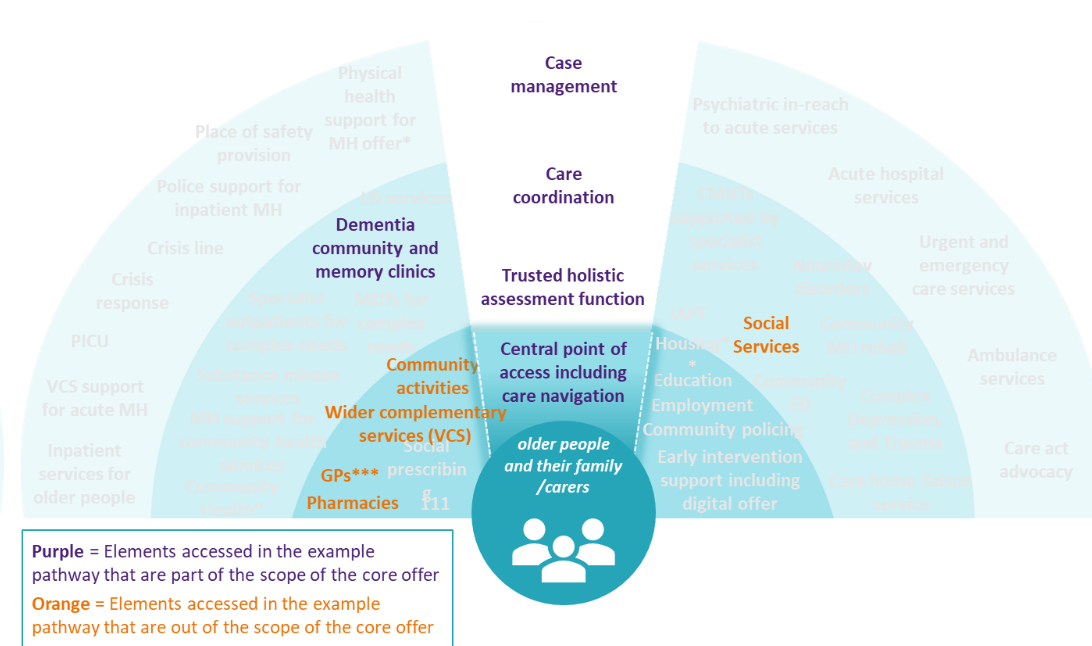
What care will look like through the core offer

The GP carries out an initial mental health assessment having received specialist training and support from the memory clinic and contacts the central point of access. This arranges for Paul to have an assessment at the local memory clinic with an older adult psychiatrist or geriatrician. Both Paul and his son's ideas, concerns and expectations are considered and a full assessment of Paul's social and living arrangements is made. The memory clinic MDT reviews the results in conjunction with the assessment and a mild-moderate dementia diagnosis is made. A holistic care plan is developed with input from Paul (as appropriate), his son, and from a social worker linked to the team who assesses the home circumstances and level of risk. Paul is allocated a case manager who acts as a point of contact for Paul, the family and any professionals and supports Paul and his family to understand the condition and make shared decisions, which prioritise Paul's preferences where appropriate, and to access local support groups (e.g. peer support). The case manager gets input from community cardiovascular team to develop a care plan and supports Paul to have a review of his sight at the optician. Paul is encouraged to join local wellbeing activities of his preference and to take part in cognitive rehabilitation therapy and stimulation therapy. Paul agrees with some encouragement from his son to start taking some dementia medication on the advice of the Memory clinic. Paul has three monthly reviews with the Memory clinic and a monthly review with his case manager. A package of care is arranged to support Paul to manage safely at home alongside support from his son. A social worker regularly reviews how Paul and his son are getting on with the potential to increase the level of carer support and/or provide respite care if required.

Community health offer



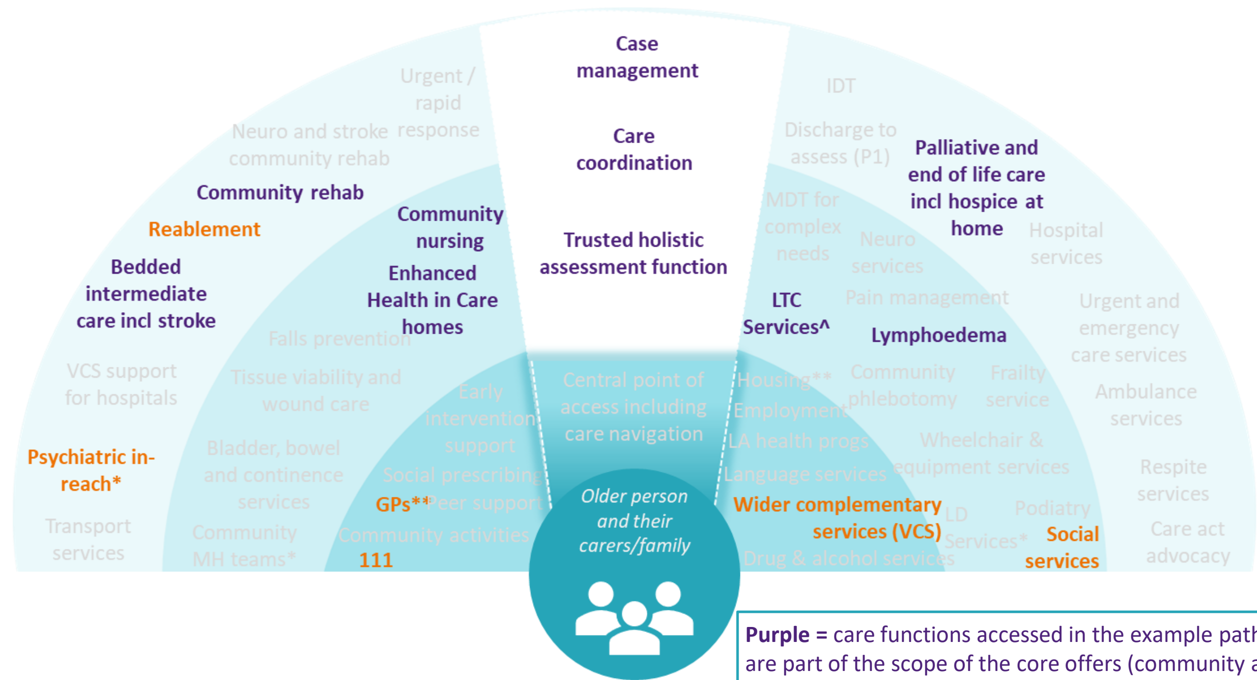
Mental health offer



Example pathway: Older adult with palliative care needs

Yasmiin is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has dementia, breast cancer, heart failure and is thought to be in last 6 months of her life.

She has had four hospital admissions in the last six months with breathlessness related to her heart failure



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Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Yasmiin is reviewed weekly by the enhanced health in care homes (EHCH) team linked to her care home. A GP in the team is her case manager and regularly carries out a holistic assessment of her needs and preferences together with her family. Yasmiin has complex and multiple needs which involve care from a number of members of the EHCH and input from wider services. The end of life care team regularly review Yasmiin and advise the EHCH on symptomatic support for Yasmiin and provide support to Yasmiin's family. They have put together an anticipatory care plan, with co-agreed limits to acute escalation of her care. Community nurses, the geriatrician and a respiratory physio from the EHCH together with end of life nurse specialists support the care home staff to look after Yasmiin when she develops worsening breathlessness from her heart failure and avoid hospital admissions. The community nurse on the team with specialist input from the lymphoedema service manage the complications of Yasmiin's leg lymphoedema. The geriatrician linked to the EHCH team advises the care home team on how best to manage Yasmiin's dementia. These members of the EHCH and wider team meet collectively review Yasmiin's care monthly at MDT led by her case manager. Yasmiin's family are supported to access local voluntary sector carer support in the community and Yasmiin is supported to join a music group weekly in the community which she enjoys.

When Yasmiin's condition does deteriorate, the end of life nurse specialist is able to set up a syringe driver in the nursing home and provide bereavement support to her family.