APPENDIX A

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	
Service	Community Matron Service including Virtual Ward
Commissioner Lead	Stephen Astles Dr Pete Chamberlain
Provider Lead	
Period	2016/17
Date of Review	

1 Population Needs

1.1 National/local context and evidence base

The Community Matrons focus on the proactive management of people with long term health conditions, supporting self-care, self-management and promoting independence; empowering and enabling patients to take control of their illnesses and to improve quality of life.
The Community Matron Service supports the requirements of, and acts in accordance with, the Case Management Competencies Framework. The service complies with local and national policies, procedures and guidelines e.g. National Institute For Clinical Excellence (NICE), National Service Framework (NSF).

The Community Matron Service supports the requirements of, and acts in accordance with the Public Service Agreement by:

- Improving health outcomes for people with long term health conditions by offering a personalised care plan for patients with a complex care need.
- Reducing emergency bed days through improved care in primary care and community settings for people with long term conditions.

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

Community Matrons provide senior Nursing Support to patients with complex needs. The patients referred should be seen within a clinically acceptable timeframe and treatment plan includes:-

- Provision of a holistic multi-disciplinary, goal-orientated rehabilitation, service designed to bridge the gap between hospital and home to post-acute patients or patients whose admission could be avoided or whose independence can be preserved, and restored in their own home
- Co-ordinate a programme of therapy and care that will maximise physical, psychological, and social functions and independence.

- Provision of continuous assessment of needs using the Single Assessment Process (SAP) with patients and carers that will facilitate decisions regarding future care
- Assessment and diagnosis in conjunction with General Practitioner/Nurse Prescribers within Community health services.
- Advice and management and administration of medication.
- Provision of a step up/down person-centred care for patients with needs met at their place of residence or clinic setting.
- Promotion of health and active lifestyles.
- Contribution to whole systems services that cross professional and organisational boundaries.
- Continual assessment of care needs with users and their carers and facilitate decisions regarding future care.
- Provision of education of patients to enable self care.
- Provide timely, responsive and appropriate assessment and discharge pathways for patients with on-going needs.

3 Scope

3.1 Aims and objectives of service

- To provide high quality and safe services that are sensitive to the changing population needs of Sefton.
- To actively identify patients
- To provide and facilitate the co-ordination of individualised holistic care for adults with co-morbidities who are high intensity service users:
- By providing advanced clinical assessments of patients, educating patients, families and carers, promoting effective self-management.
- Intervening in crisis situations for patients known to the Community Matron, providing appropriate treatment and management at a patient's place of residence, thereby preventing unnecessary hospital admissions.
- To liaise with secondary care to facilitate early discharge of patients onto the Community Matron caseload.
- To apply advanced clinical and leadership skills to ensure that the most appropriate care and support are delivered at all times.
- To ensure integration and partnership working with other agencies through support, education and mentorship.
- To encourage patients/carers to adopt a healthy lifestyle. This includes referral on to the Carers Centre and other social care and voluntary service to meet identified need.
- To assess, plan and provide high quality individualised care. This includes user satisfaction and experience and ways in which service delivery can be adjusted and improved.
- To provide a seamless service with other health professionals and statutory/non-statutory agencies.
- To prevent unnecessary hospital admissions.
- To enable individuals with long term conditions to achieve quality of life and independence.
- To prevent unnecessary General Practitioner ((GP) appointments and home visits.

3.2 Population covered

All patients registered with a South Sefton GP.

3.3 Any acceptance and exclusion criteria and thresholds

Patients under the age of 16 years.

3.4 Interdependence with other services/providers

All Primary and Secondary care professionals, statutory and voluntary organisations including:

- Community nursing staff
- General Practitioners
- Allied Health Care Professionals
- Hospital staff
- Specialist Services
- Intermediate Care Service
- Out of Hours Services
- Ambulance Service
- Social Care Team
- Support Services
- Pharmacies

4 Applicable Service Standards

There is an expectation that the provider will adhere to all national, regional, local multi-agency; legislation, policy, procedures, best practice and internal policies relating to adult and children safeguarding.

Information Recording and IM&T Requirements

Referrals into the service should be processed electronically. To facilitate this, providers must be Choose & Book compliant, or working towards compliance. Initial appointments must be directly or indirectly bookable through Choose & Book.

Across North Mersey the main strategic system in use across primary and community care is EMIS Web. The EMIS Web clinical system facilitates the capture of clinical interactions (e.g. caseload management, clinical assessment, patient consultation and care planning), clinical decision making at the point of care for primary care GP clinicians and a variety of community based services whilst also enabling full integration of Multi-disciplinary Teams (MDTs).

The iLINKS information sharing framework has been designed and developed to provide a structured framework to facilitate information sharing, ranging from basic demographics and summary information sharing, through to access for practitioners to view full electronic health and social care records. The model is based upon roles and service profiles of practitioners, with specified roles and services having access to a defined set of information based on need and risk. All providers of health and social care across the North Mersey region must sign up to and deliver all principles set out in the North Mersey Information Sharing Framework.

A messaging hub (Medical Interoperable Gateway) is in use across the Health Economy and it is expected that where relevant, this is used for standardised clinical documents to be sent in a timely manner.

The provider must ensure that they comply with the Good Practice Guidelines for Electronic Health Records and that they have all the necessary systems and processes in place to comply with all NHS information governance requirements.

Providers must ensure that the storage of medical records and information which is relevant to treatment and on-going care is passed between all parties in accordance with Caldicott Principles (1997, 2003) and the Data Protection Act (1998). In addition the provider should also;

- Ensure that service provider activity, performance data and clinical audit will be extracted electronically from the clinical system
- Ensure that all members of staff are adequately trained in the use of the relevant information

systems.

- Have robust business continuity with regard to their IM&T systems to ensure that services are not affected and to safeguard information.
- Ensure that patient records are transferable in the case of the provider ceasing to provide NHS services or in the case of the patient changing to another provider. This preferably should be done electronically.

Equality & Diversity

- To collect and act upon/analyse patient experience data and seek views from relevant protected and vulnerable groups and need to demonstrate how this supports service improvements. This could form part of the eq5d contract monitoring KPI and could form part of the role of EPEG – Jan 2016.
- To be cognisant of their statutory duties to involve, consultant and meet the relevant Equality Duties if the provider proposes further changes to service delivery. The commissioner will need to be notified of changes and have assurances that changes to delivery and done in line with these statutory requirements. The equality Assessment needs to form part of the future discussions when changes to care models are discussed between providers and commissioners – Post April 2016.

5 Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

5.2 Applicable CQUIN goals (See Schedule 4E)

6 Location of Provider Premises

The Provider's Premises are located at:

7 Individual Service User Placement