

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement  
Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

<b>Service Specification No.</b>	
<b>Service</b>	Primary Care Urgent Care Service
<b>Commissioner Lead</b>	Mark Atkinson
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

#### 1. Population Needs

##### 1.1 National/local context and evidence base

The White Paper ‘Equity and Excellence: Liberating the NHS’<sup>1</sup> has the driver to improve health outcomes. This is supported by greater accountability to the public and strengthened regulation. Specifically, commissioners are tasked to develop a coherent 24/7 urgent care service that makes sense to patients when they have to make choices about their care. The Department of Health review of urgent care lists some expectations of patients in healthcare. Services should:

- Be quick.
- Be simple to access.
- Put patients in control.
- Support patients to prevent ill health.
- Be available close to or in patients’ own homes.
- Ensure patients feel that the advice received will keep them safe.

To facilitate this, a new single telephone number, NHS 111, has been introduced which will improve the quality, efficiency and coherence of urgent care services. This means that any future development of primary care urgent medical services will need to fit within this model of care.

The commissioner must develop coherent 24/7 urgent care services, supported by

<sup>1</sup> DH (2010) Liberating the NHS [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213823/dh\\_117794.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf)

the NHS 111 single telephone number, which helps patients to access the right services in the right place, at the right time, from the right care professional. The Health and Social Care Act builds on this and highlights the need for a more integrated approach so that patients have a seamless experience of health and social care. The emphasis is on creating a simple system that guides patients to the right place to receive care. The evidence base to support the national context is as follows:

- The Operating Framework for the NHS in England 2014/15
- The Health and Social Care Act 2012
- Department of Health - Liberating the NHS, 2010
- Healthcare Commission - Not just a matter of time: A review of urgent & emergency services in England, 2008
- Department of Health - Taking Healthcare to the patient, 2005
- Primary Care Foundation - Urgent Care a practical guide to transforming same-day care in general practice, 2009
- Primary Care Foundation - Benchmarking GP Out of Hours service, 2010
- Primary Care Foundation – review of urgent care centres, 2010
- College of Emergency Medicine – The Way Ahead, 2008
- The Direction of Travel for Urgent Care: A Discussion Document; DH; 2006
- Department of Health - Urgent Care, Direction of travel, Consultation document, 2005
- GP Patient Satisfaction Survey - conducted by MORI annually
- A Guide to Patient and Public Involvement in Urgent Care

The entire urgent care needs of the population cannot be delivered within the same framework and resources as emergency care. It is not appropriate for accident and emergency to be regarded as 'anything and everything' or for the emergency department to be 'everyone's default. It is unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions.

Evidence suggests that General Practice provide urgent care more cost effectively, where cases are appropriate to primary care and General Practice continues to deal with most of the urgent care activity during usual opening hours. There is little room, however, to increase activity in primary care, and it is currently not configured to tackle the activity out-of-hours. It has been proven, however, that effective reorganisation of primary care out-of-hours services can result in the numbers of referrals to A&E reducing and an increase in the use of out-of-hours<sup>2</sup>.

The growing body of evidence that primary and community teams should be physical co-located within the emergency department to bridge the gap between hospital and primary and social care and to support vulnerable patients is

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<sup>2</sup> Van Uden C.J., Crebolder H.F. (2004) Does setting up out of hours primary care co-operatives outside of a hospital reduce demand for emergency care

persuasive. The teams co-located within emergency departments should include primary care practitioners, community teams, social workers and mental health professionals<sup>3</sup>. Co-location enables patients to be streamed following a triage assessment. This also enables collaborative working including sharing of diagnostic facilities, reduces duplication of administrative tasks and permits patients to be easily re-triaged should further assessment require so<sup>4</sup>.

The urgent care system is complex and often disorganised with opaque systems to their users. This can lead to fragmentation of service provision, impacting on quality of care and efficiency of the system as a whole. Healthcare organisations should be seen as conglomerates of smaller systems, a microsystem, and not coherent monolithic organisations<sup>5</sup>. Microsystems are defined as small, functional, multidisciplinary front line units that provide the majority of healthcare to patients<sup>6</sup>. There is a growing body of evidence for the effectiveness of microsystems as an approach to improve healthcare and the integration of services<sup>7</sup>. Excellent services are attainable in microsystems that understand what really matters to a patient and family and have the capacity to provide services to meet the patient's needs<sup>8</sup>.

Critical to the success of a model where you have integrated primary care units within A&E units, is ensuring that services are clearly defined locally. Clear boundaries between primary care, MIUs and A&E need to be defined locally for patients<sup>9</sup>. In addition commissioning a primary care assessment unit in A&E should be strategically aligned to the reorganisation of local out-of-hours services and community services that provide reactive, urgent care provision to the local community [*ibid.*].

Patients attending A&E departments with minor illnesses, which were assessed by GPs as capable of being managed in a general practice setting, make up approximately 10 – 30% of the average caseload of a UK A&E department<sup>10</sup>. There is a growing body of evidence that a true see and treat model within A&E, delivered by primary care practitioners, can impact on waiting times and reduce emergency admissions and diagnostics [*ibid.*]. There is also some evidence that it can result in a shift of emergency consultations from secondary to primary care<sup>11</sup>.

Primary care can play a key role in changing culture communication and treatment within A&E. Primary care practitioners are seen to enhance emergency departments by bringing vital skills and expertise to a multi-disciplinary team, though it is

<sup>3</sup> The college of Emergency Medicine (2014) Acute and emergency care: prescribing the remedy

<sup>4</sup> NHS England (2013) The Keogh Urgent and Emergency Care Review – end of stage 1 engagement report. [www.nhs.uk/NHSEgnaldn/keogh-review/Documents/UECR/Ph1Report.FV.pdf](http://www.nhs.uk/NHSEgnaldn/keogh-review/Documents/UECR/Ph1Report.FV.pdf)

<sup>5</sup> Mohr. J.J (2004) Integrating patient safety into the clinical microsystem. Quality and Safety in Healthcare

<sup>6</sup> Batalden, P.B. (2003) Microsystems in health care: part 9 : developing small units to attain peak performance. Joint Commission Journal on Quality and Safety

<sup>7</sup> Wasson, J.H (2003) Microsystems in health care: part 4: planning patient centred care. Joint Commission Journal on Quality and Safety

<sup>8</sup> Williams., I. (2009) Clinical microsystems in the NHS: a sustainable method for improvement? Journal of Health Organization and Management

<sup>9</sup> Sanders J. (2000) A review of health professional attitudes and patient perceptions on inappropriate A&E attendances. The implications for current minor injury service provision in England and Wales

<sup>10</sup> Primary Care Foundation, DH (2010) Primary care and emergency departments

<sup>11</sup> Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

important that there is a clear recognition of the skills of each group of clinicians and mutual respect<sup>12</sup>.

### 1.2 Local Needs in West Kent

West Kent CCG has a registered population is 466,000, 31% of the total Kent registered practice population<sup>13</sup>. The CCG has 63 practices and covers the resident population from the local districts of Maidstone, Tonbridge & Malling, Tunbridge Wells, majority of Sevenoaks (except Swanley ward which is covered by the Dartford Gravesham and Swanley CCG) and two wards within the local district of Ashford. There is also a very small part of the population of the T&M District Council catchment historically serviced by practices located in Medway and which are aligned to Medway CCG.

Although the age profile of the population is broadly similar to that of Kent and Medway as a whole West Kent has a:

- Slightly larger proportion of 35 to 54 year olds and smaller proportion of 20-29 year olds.
- 7% of the population of the four districts is of black and ethnic minority origin.
- The percentage of the BME population is higher in those of working age compared to the 0 to 15 age group and those who have retired.

Over the next twenty years the overall population of the four local authorities is expected to increase. Using resident populations for the districts of Maidstone, Sevenoaks, Tonbridge and Malling and Tonbridge Wells, the following changes are predicted:

- The under-five population will remain fairly constant with an increase of less than 4% over 20 years.
- The population aged 5-19 will increase by just over 12.5% across that period
- The population of 65+ is set to increase by 57.3% from 2011 to 2031 increasing from 88,300 to 138,900 and within this the population of 85+ group is predicted to increase by 127.3% during the same period, 12,100 to 27,500.

This increase has important implications for health and care delivery from both a financial and activity perspective. For example, over 65s are:

- 18 times more likely to suffer long term heart/circulatory problems
- 20 times more likely to suffer with eye conditions
- More likely to be high users of services

### 1.3 The local urgent care system

Hospitals are struggling to cope with increasing pressure on urgent and emergency care services. West Kent is seeing a year on year increase in the numbers of A&E attendances. The majority of activity is between 9.00am – 7.00pm, in line with national trends. At Maidstone Hospital 64% of A&E attendances are classified as minors. This is slightly less at Tunbridge Wells Hospital (40%). Over the last year,

<sup>12</sup> Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

<sup>13</sup> Working together to Keep Kent Healthy: Joint Strategic Needs Assessment. <http://www.kmpho.nhs.uk/jsna/>

however, there has been a 15% increase in the numbers of minors attending A&E with the majority of the increase in activity at Tunbridge Wells. For the 75 and overs there has been a gradual increase in the number of A&E attendances with no apparent seasonality.

Local analysis shows that there are three groups where A&E attendance is disproportionately high: the under 5s, 20-24 years and >80yrs. Conversion rates from A&E attendance to admission appears to gradually increase with increasing age. 70% of the above 85 year age group attending A&E are likely to be admitted.

Though overall numbers of emergency admissions have remained static there is a year on year increase in the number of emergency admissions for the over 75s and a significant increase in the numbers of short stay non-elective admissions.

Data from the Hospital Episodes Statistics shows that the proportion of people aged 65+ and over who are admitted to their hospital from their own home and discharged to residential and nursing care is relatively high for Kent (and the Home Counties generally) compared to other parts of the country, suggesting that this is an area where improvement is needed.

A significant proportion of all acute hospital activity is related to ambulatory care sensitive conditions (ACS). Structure use of pathways for ambulatory care sensitive conditions, commissioned by West Kent CCG, has reduced long stay emergency admissions by shifting activity to same day care.

Our data clearly shows that the largest proportion of urgent care activity is related to older people with health and social care needs linked to dementia, falls and perhaps end of life. This cohort will be complex, have multiple morbidities requiring an integrated health and social approach which can be successful depending on a whole systems transformational change towards an integrated care team approach using risk stratification and patient empowerment methods through self-care and self-management.

The roll out of NHS 111 has led to some incidents of poor patient experience and unnecessary A&E attendances during early implementation and consistent positive patient experience of ambulance services and confusion surrounding other areas of urgent and emergency care services may have contributed to an increased use of the emergency (999) number and ambulance services by patients with non-urgent healthcare needs.

The national and local trend for 999 calls is on the increase, but in West Kent this is not resulting in an increase in the numbers of patients conveyed to hospital, during in-hours periods. There is, however, an increase in the numbers of patients who are conveyed to hospital out-of-hours. In 2013/14 a total of 41,486 patients accessed out-of-hours services with approximately 40% of patients receiving telephone advice, 50% were treated at the out-of-hours treatment centres and 10% were treated at home.

#### **1.4 West Kent CCG Strategic Aims for 2015 - 2020**

West Kent CCG has established six strategic aims which tackle the key priorities for the West Kent Health economy. These aims are to secure:

- A thriving local NHS provider landscape for the West Kent population which delivers safe and high quality urgent and non-urgent care.

- Improved patient and carer experience for End of Life Care.
- Improved and integrated health and social care packages for the elderly population.
- Supported and enhanced healthcare provided by General Practice
- Engaged and empowered patients who are able to manage their own health and make informed decisions
- Improved Value for Money and outcomes for Mental Health conditions including dementia

A key aspiration of the West Kent CCG Strategy, Mapping the Future, is to develop a new model of primary care. Part of that new model will include redesigning the traditional out-of-hours service so that it becomes an integral part of new primary care rather than a separate element. The aspiration is that they will take on a wider range of functions supporting GP practices and will include supporting the provision of in-hours urgent care, incorporated within GMS and PMS contracts. This will include multidisciplinary teams providing urgent care flexibly, for patients who require urgent or emergency care, such as see and treating primary care type patients who attend A&E.

We are working towards delivering a network of integrated services that are able to treat patients in their own home, preventing unnecessary hospital attendances. This includes working towards hospital at home & virtual ward models of care, in order to treat a greater number of acutely unwell and ambulatory care patients in the community.

Under this strategic focus the key deliverables and areas for particular focus relevant to the delivery of a primary care urgent medical service are:

1. Supporting the wider introduction of NHS 111 locally in a way that does not result in increased A&E attendance
2. An emphasis on making best use of an integrated intermediate care service that provides a rapid health and social care response to support people at home
3. To work more closely with Maidstone and Tunbridge Wells NHS Trust as the main provider of acute care to deliver the four hour access target and early supported discharge
4. Developing pathways to reduce A&E attendances/emergency admissions and tariff based spend while supporting the CCG's priority areas
5. Develop more community services to avoid a transfer to hospital based care
6. Working with the ambulance service to care for more people in the community, decreasing conveyances to hospital

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

	Improvement Area	Indicator
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<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	<b>Emergency admissions for acute hospitalization that should not require admission</b>
		<b>Proportion of people who recover from Trauma</b>
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	<b>Patient experiences of A&amp;E services</b>

## 2.2 Local defined outcomes<sup>14</sup>

1. Reduction of A&E attendances and emergency admissions
2. Delivering high quality, safe and clinical sustainable services which meet required standards of care and are safe 24/7
3. Increase use of alternative services to ensure a continued focus on prevention and self-care
4. Ensuring patients receive the right advice at the right time and place
5. Connecting urgent care services together more efficiently to reduce a fragmented and complex system

See section 6 for monitoring requirements and key performance indicators

## 3. Scope

The service will provide an integrated service, delivering both urgent primary care and hospital at home services for West Kent residents. The team delivering the service must be multidisciplinary, in order to meet the requirements and needs of patients for both a primary care service and a hospital at home service. The service will function as a microsystem providing the majority of care for the following cohort of patients: (See section 3.8 for full acceptance criteria)

- Patients who may be at risk of a hospital admission and can be treated within their own home or at alternative community based facilities (e.g. community hospitals).
- Patients who have a primary care need and are referred directly by NHS 111
- Patients who attend A&E with a primary care need

The service must provide out-of-hours primary care medical services; based at primary care medical assessment units, co-located within the two A&E units in West Kent. The provider may wish to identify further community settings, for out-of-hours treatment centres, as deemed appropriate, to ensure all the needs of the West Kent population are met.

The primary care medical service element will not solely focus on out-of-hours provision but must extend to normal working in order to triage and treat primary care patients attending A&E both in-hours and out-of-hours. This will help support patient

flows through the hospital during its busiest periods.

All patients who are assessed as potentially needing a hospital admission will be further assessed for suitability for the hospital at home service. This may be patients who are triaged and assessed through the primary care medical assessment units or by a health professional, triaging a patient within their own home, who refers on to the hospital at home service.

The service must also work closely with MTW's discharge teams & primary care teams to facilitate early discharge of patients, providing a step down service for patients who are assessed as being medical fit.

There must be leadership and oversight from a specialist acute physician, in order to assess and agree treatment and care plans, and provide ongoing monitoring as appropriate, for those patients who are deemed suitable for the hospital at home service. This is critical to ensure appropriate clinical governance, patient safety and quality of care is maintained within a virtual ward model of care.

The provider must ensure all appropriate support and resources are in place, including nursing and therapeutic services and prescribing, to provide the appropriate level of care for patients within the primary care medical assessment units and within the community.

### **3.1 Aims and objectives of service**

- To provide a safe/high quality patient friendly primary care urgent care service for the registered, unregistered and resident population of West Kent.
- To encourage and facilitate providers to work together to deliver care that is centred around patients, responsive, safe, resilient, and fit for purpose to ensure patients receive the right care, in the right place, at the right time.
- To ensure a smooth and apparently seamless handover of care between provider organisations
- To ensure that whenever appropriate patients are safely cared for within the community so integration with practices and other primary and community services is critical.
- Involve patients and carers in the development, implementation and evaluation of care/treatment plans, which are appropriate shared with other relevant providers
- Have a planned outcome of maximising independence and enable users of the service to resume living at home independently wherever possible. Service users should be assisted with relearning independence techniques with personal care which may include assistance and retraining in washing, dressing, using the toilet, food preparation, essential shopping and the taking of medication
- To support the delivery of the vision and objectives of the CCG through the individual interactions with patients.

### **3.1.1 Specifically this means providing a service that:**

- The service is clinically safe and is subject to the appropriate clinical governance of the employing organisation
- Provides prompt and convenient fully integrated primary and community care
- Provides an excellent patient service
- Manage conditions not requiring an acute hospital admission, examples of which include urinary tract infections, cellulitis, administration of drug using nebulisers, intravenous therapies, oxygen therapy.
- Undertake diagnostic tests as indicated, interpret and implement an appropriate management plan including appropriate treatment, remote or direct monitoring, urgent bloods, radiology, ECGs
- Gives value for money, bearing in mind the benefits of reducing usage of other services such as secondary care
- Is sustainable, attracting and retaining good competent primary care and community clinicians with local knowledge and also fosters local clinical engagement
- Meets the quality requirements for urgent care services together with other relevant standards, recommendations and good practice guidelines
- Makes use of clinical records to provide good care to patients and ensure that the record of each contact is complete and made available to other health professionals (See Section 4 for IM&T requirements)
- Works collaboratively and in the interests of the whole health system, for example to ensure that patients are provided with the most clinically appropriate pathway for their condition so that any impact on A&E attendance, admissions and pressure on GP in-hours services, is appropriate and justified.
- Makes imaginative use of technology to support the service aims whilst providing a robust framework and strong business continuity backup
- Is actively managed in a way that involves patients, practices, staff, commissioner and other stakeholders in developing the service

### **3.2 Service description/care pathway**

- To ensure a GP is available to be involved in the assessment of patients at the primary care assessment units, and to carry out home visits at all times.
- The primary care assessment units, though co-located within the A&E departments and will work closely alongside the emergency department teams, they will need to operate independently and will not be part of the hospital system in order to effectively filter primary care type patients away from A&E
- The expectation is this will be a GP lead service. This is a minimum

requirement and it will not be deemed safe to operate the service without the physical availability of GPs to carry out this task.

- Face to face consultation &/or home visits must be undertaken by suitably trained and experienced staff. This should be a GP, unless the clinical indications are such that another suitably qualified health professional will be able to provide the care needed, e.g. blocked catheter, dressing required, etc. Where appropriate consultations and home visits can be carried out by a nurse practitioner, paramedic or therapist.
- Provide telephone advice as part of the definitive clinical management of calls, ideally in such a way that this is provided as a seamless part of the call-handling service provided by the NHS 111 provider, through integration and coordination. Telephone advice should only be given when clinically appropriate following the appropriate procedures
- Enable the “primary care” stream of patients to be seen more appropriately within A&E, improving patient experience by avoiding unnecessary admissions/diagnostic tests, providing additional capacity within A & E, and providing training/influencing of acute doctors
- Provide rapid response 24/7 (including weekends) to people who would otherwise face unnecessary admission to acute in-patient care or unnecessary prolonged hospital stays, long term residential care, or continuing NHS in-patient care;
- To facilitate timely discharge from A&E, an acute or community hospital back to their own home or where appropriate discharge to the Romney ward
- Provide support to GP services by assessing and treating people, who require primary care services out-of-hours or meet the hospital at home criteria, in their own homes which includes Residential and Nursing Care, Extra Care Housing and Day Care Services.
- Deliver therapeutic medical and nursing input in a cohort of patients in the patient’s usual place of residence instead of the current arrangements of delivering the same in a secondary care setting
- Prescribe medicines as required in accordance with legislation and in line with the local formulary and any national or local guidelines. Where appropriate medicines are to be provided and/or administered to patients
- The service will at all times maintain a contemporaneous record of all consultations documenting clearly any changes in management and the reason for such changes. The provider will be asked to report on this so that the commissioner can review the accuracy of the initial clinical determination and work with NHS 111 to review their outcomes.
- Maintain and share as appropriate good quality clinical records with adequate coding to support analysis, reporting and service improvement and to maintain details about each encounter with each patient to provide a full record of the service provided
- Maintain facilities, equipment, vehicles communication and information technology systems etc. to support the service

- Provide, train and manage appropriately skilled clinical staff and support staff to cover such areas as driving despatch and response to calls
- Prepare and maintain suitable resilience and contingency plans and train staff in their use to provide a resilient service that can respond to system outages, facilities being inaccessible, major incidents and surges in demand
- Establish relationships and ways of working to facilitate clinicians from the primary care assessment units and the hospital at home service to integrate packages of care around the needs of individual patients drawing in other specialist, primary, community or social care services.
- Operational integration with services to ensure seamless patient flows. This should include integration with NHS 111, A&E and SECamb.
- Support individual unregistered patients to help them to register with a practice.
- Meet statutory, regulatory and good practice requirements that are relevant including in respect of governance, safeguarding children and vulnerable adults, the mental capacity act, health and safety, accessibility and those in the health and social care act or recommended by such bodies as the department of health, care quality commission etc.
- Provide the commissioner with assurance that in light of the Francis report, services developed are based on quality, effectiveness and patient safety and that it is recognised rigorous monitoring arrangements will need to be in place to monitor compliance.
- Promote the service in an appropriate manner that ensures all patient groups have access to helpful and informative information using different mediums of communication
- Be proactive in managing all aspects of public and patient relations

### **3.2.1 Assessment**

- The service will complete a comprehensive assessment within an appropriate timescale for all patients referred into and accepted onto the service.
- Acute management will be undertaken, either within the primary care assessment unit or at the patients usual place of residence, by support team – virtual and direct (physician, senior & junior nursing, physio, OT, social worker, HCA etc)
- For patients being treated by the hospital at home service initial and all on-going assessments will be completed in consultation with the patient, the patients family and social services
- The referral will be returned to the patients GP if suitable for management by primary care.
- If an assessment deems the patient is unsuitable at the point of referral or at a later stage e.g. due to a change in need advice, support and alternative arrangements will be made. A re-assessment will take place within 24 hours with a view to securing more suitable care. This should, be facilitated within

48 hours

- When a person has been assessed as requiring long term care, it is imperative that they are appropriately referred to ensure the service user receives the most appropriate care, by the right person in the right place at the earliest opportunity.

### **3.2.2 Care Planning**

- Where appropriate patients accepted will have a personalised care plan in place, completed to local standards. This care plan will be developed in full consultation with the patient and the patient's family. Care plans for patients in care homes and residential homes will be completed in consultation with the staff of that home
- All care plans will be documented in case notes and retained at the patients' location. Care plans will be holistic in their approach and will be shared with other relevant care professionals
- The provider will put in place systems and processes to ensure quality standards for the completion of care plans are met. The provider's standards will align with national standards and policies and any key changes in these during the life of the contract.

### **3.2.3 Discharge planning**

- Discharge planning shall commence from the date of the referral and shall be person-centred and flexible, to meet the needs of the patient. The patient and/or carer shall be consulted regarding the discharge plan and the potential date for discharge shall be identified and communicated as appropriate.
- Discharge planning will form an integral part of the patients programme and the service will provide acute case management until the patient is clinically stable and safe to be discharged to Primary care and/ or social services.. The team will ensure referrals are made to the required community services as early as possible ensuring continuity of care/rehabilitation
- Following discharge from the service appropriate information, advice, guidance and sign posting will be provided to the patient and their carer, and robust handovers will be undertaken with other care professionals
- The team will complete and send a discharge summary report within a week to the GP and other agencies where appropriate

### **3.2.4 The provider must:**

- Ensure that the patient understands the outcome of their assessment and are kept informed of any related follow-up actions.
- Provide suitably equipped vehicles for home visits. Vehicles must be equipped with up-to-date communications and navigation aids and comply with relevant legislation.
- Ensure the GP/suitably qualified clinician has access to secure mobile devices to record their consultation and view notes where appropriate, which

should be done as soon after visiting the patient as possible.

- Have in place a clear system of recording to facilitate the GP/suitably qualified clinician being aware of previous requests for a home visit and any treatment provided to ensure continuity of care.
- Clinicians should be provided with a system that makes it easy for them to record full details of the consultation (at the treatment centre or at a patient's home) onto the system in a suitably secure way. The provider should take responsibility to check that coding, clinical notes, referral information etc. is reliable and complete
- Have in place escalation procedures for patients who have been seen twice or more in the same 48 hours (unplanned) to review presenting symptoms and consider whether alternative management is required.
- Have in place escalation procedures for patients who are repeat and frequent callers to review presenting symptoms and consider whether alternative management is required.
- Ensure that protocols and processes are in place to ensure the health and safety of the visiting member of staff is secured.
- Prioritise all calls in terms of clinical urgency and response and comply with the timeframes as set out in National Quality Requirements below.

### 3.3 Service elements

#### 3.3.1. Telephone consultations

The provider will complete telephone clinical consultations for patients received/referred from NHS 111.

Once the patient details/referral is received from NHS 111, the clock will start in terms of commencement of the definitive clinical management process. The referral will give an indication of the urgency of the response which out-of-hours clinicians must respond to within the specified timeframe.

The out-of-hours GP is expected to complete the telephone clinical consultation with appropriate advice, arrangement of a face to face consultation or arrangement of a home visit. The GP will clarify any points or gaps in information with the patient by telephone and will review the urgency of the presenting medical need to determine the most appropriate outcome.

During the completion of the telephone clinical consultation the GP must ensure the patient understands the outcome of their assessment and are kept informed of any related follow-up actions. The GP will determine the urgency of the consultation and make an appointment linked to this assessment. Patients must be told the time of their face to face appointment and be given details of how to get to the out-of-hours treatment centre.

The GP may present the following options to the patient:

- Offer advice about the presenting need, reassure the patient and discharge them from out-of-hours care.

- Offer advice to the patient, if the presenting symptoms do not need urgent medical intervention, and direct the patient to contact the in-hours GP service.
- Direct the patient to a local pharmacy, taking note of opening days and times and being aware of pharmacies with extended or 100 hour per week opening.
- Make a referral to district nursing or other community services including on-call palliative care services.
- Arrange an appointment for the patient to be seen for a face to face consultation.
- Arrange for a home visit

The expectation is that GPs will work from a primary care assessment unit and be an active part of the range of clinical responses to patients. Care must be taken to link any previous calls by maintenance of an electronic record summarising all calls. This is to ensure there is continuity of care and, if the initial contact has not resolved the patient's presenting condition/concerns, for further action to reduce the risk of exacerbation of the patient's condition.

### **3.3.2 Face to face consultations (Primary Care Home visits)**

The provider will provide an out-of-hours home visiting service to all patients where the 111 completion of the telephone clinical consultation has determined that this visit is required. The provider will offer assessment, diagnosis, treatment or treatment plan, make arrangements for onward referral, follow-up or discharge and prescribe/dispense medicines as required.

Circumstances that will lead to a patient receiving a home visit will be determined by the provider's protocols, which must be agreed with the commissioner, as well as the clinical judgement of the clinician involved with the case. For all patients who request a home visit as opposed to a consultation at an out-of-hours designated treatment centre where the decision is made by the GP/suitably qualified clinician not to visit, the reason not to visit must be recorded.

Patients who have an immediate need to be seen by a GP are:

- Patients in the late stages of a terminal illness.
- Patients who are housebound and/or bed bound'.
- The frail, elderly or vulnerable
- Patients for whom an immediate car journey could lead to an unnecessary deterioration in their condition or unacceptable discomfort, or whose condition precludes travelling.
- Parents alone with young children, whose circumstances preclude travelling, for example two or more other siblings cannot be left home alone while parent accompanies child for treatment or requires treatment themselves

Patients who are suitable for the hospital at home service, particularly frail elderly, will be assessed and a treatment and care plan agreed in order to prevent

inappropriate admission and investigations.

### **3.3.3 Face to face consultations (Primary Care Assessment Units / OOHs treatment centres)**

The Provider will offer face to face consultation conducted by an appropriately trained clinician according to the assessed patient's needs.

The Provider will offer face to face consultation that will include: assessment, diagnosis, treatment or treatment plan, or make arrangements for onward referral, follow-up or discharge and prescribing of medicines as required

The consultation will take place at a designated treatment centre or (where, in the light of the patient's medical condition and social circumstances (for example being 'housebound'), it would not be reasonable to expect them to travel) can take place at the patient's home location

Patients will be seen promptly based at the booked appointment time, but recognising the need to prioritise those patients that are more acutely ill or where there is a requirement for urgency

The provider should make use of a suitable system so that the status of each patient can be viewed, appointments, arrival and patient contacts are recorded and the queues and processes can be managed. This detail forms part of the record of care and should be part of or linked to the clinical record of the episode of care

The provider must ensure there is a multidisciplinary team working within the primary care assessment units which should have input from primary care (GPs), nursing, mental health and social care.

The team must be able to link back to their respective organisations in order to enable effective 'rapid access' dispositions to their respective organisations for patients if and where there is a need, in order to manage patient care competently.

The team will be required to liaise with and work alongside other health and social care services in order to: draw in specialist expertise as required; improve efficiencies; as well as preventing duplication of staffing and skills. This will require staff to have a robust knowledge of the range of locally commissioned services.

#### **The Provider must:**

- Ensure receptionists, telephone and other non-medical staff who are providing a service to patients have access to adequate medical supervision, by at least a nurse.
- Prioritise all calls in terms of clinical urgency and response, and comply with the timeframes as set out in National Quality Requirements.

### **3.3.4 Face to face consultations – (patients triaged from A&E)**

The Provider's clinicians will operate a see and treat service, delivered to those patients that are assessed as appropriate to be seen as part of a primary care stream of patients:

- Patients arriving in the A&E by their own efforts will be assessed and triaged

by a triage nurse.

- Using an agreed list of conditions, the triage nurse will identify those patients that are suitable to be seen by the clinician in the primary care assessment unit.
- Patients who are suitable for the hospital at home service, particularly frail elderly, will be assessed and a treatment and care plan agreed in order to prevent inappropriate admission and investigations.
- The clinicians will advise patients on alternative/more appropriate service (particularly primary care) that they could have contacted and how they can be accessed.
- The discharge report to the patient's GP practice will highlight where there has been a "primary care attendance" to the A&E.
- Where a patient requires additional follow-up or referral to another specialty the clinicians in the primary care assessment unit will work with A&E and other clinicians as appropriate to explore alternative pathways to admission.

### **3.3.5 Hospital at Home**

Provide responsive support to patients in crisis through the provision of short-term, clinical care and acute rehab, with on-going assessment and, where needed, referral for longer term treatment or community support

Provide medical, nursing and social input to patients at home during an exacerbation of a long term condition, or during a period of illness or loss of function that does not require an acute admission;

Provide support and expertise post-surgical intervention or acute hospital stay for people who are medically stable but have a short term reduced level of independence than that prior to admission

A senior nurse practitioner/physician will undertake the initial assessment in the community within 2 hours. Bloods will be taken where required. The care plan will be discussed and agreed with physician for treatment, monitoring frequency and reablement. Consultant physician in most cases will be involved virtually but may need to undertake a face to face assessment. Patients on the Hospital at Home caseload will be discussed by the lead physician at least once a day.

### **3.3.6 Medical capabilities of the urgent primary care and hospital at home service**

These are the suggested medical capabilities which the service should have, but are not limited to those stated below;

- Appropriately trained General Practitioners
- Senior clinical nurses (Band 7 or 8) or paramedics with clinical skills to physically assess acutely unwell patients that meet the service criteria.
- Acute physician/geriatrician support who will discuss and agree on management and monitoring plan for each case. This support could be mostly virtual but based on their risk and clinical assessment should be able

to provide a face to face assessment in a minority of cases. This support should be available 24 hours and should be both treatment initiation and continued management.

- Skills to meet internal clinical governance and risk management standards.
- Prescribing and drug dispensing capability including SBOT (short burst oxygen therapy) and nebulizer therapy and anticipatory prescribing
- Short-term virtual monitoring systems like tele-health. IT capabilities for transmission of photographs (eg leg cellulitis)
- Advanced skills in the diagnosis and treatment of complex health conditions including acute confusion and dementia
- Treat diagnosed conditions not requiring an acute hospital admission for example urinary tract infection, cellulitis, administration of nebulisers, oxygen therapy
- Administer intravenous therapy for a diagnosed cause (antibiotics, iron and fluids ) and cannulation
- Undertake diagnostic tests, interpret and implement an appropriate treatment plan including remote or direct monitoring, routine blood tests, urgent bloods, radiology access, ECGs
- Provide short term rehabilitation and reablement services including occupational therapy and physiotherapy
- Effective symptom control and pain management including syringe drivers
- Successfully support patients to have a good death in their usual place of residence
- Assess and manage falls
- Provide self-management techniques in the patient's own home
- Provide patients with responsive and timely access to equipment to promote independence or assist in their care, including using assistive technology appropriately and show demonstrable benefit to patient outcomes.
- Provide short term input for the following (and refer to the LTC community nursing service where longer term care is required);
  - Continence care
  - Insulin therapy
  - Wound management
  - Venepuncture and cannulation
  - Alternative feeding

There must also be;

- Access to in-house or subcontracted support services like OT, physiotherapy etc
- Nursing and HCA support for continued care and monitoring
- Robust team working between the support services, the acute Physician and primary care practitioners with virtual and real MDTs, case reviews and

CME.

### 3.4 Access

The single point of access for patients will be through NHS 111 or self-referral via A&E. NHS 111 service will undertake the initial clinical assessment of the patient and determine the outcome of that process.

#### 3.4.1 The provider must:

- Establish a single point of access for health professionals, where the health professional referring to the service can make a clinician to clinician referral.
- Manage the timings of the availability of telephone and face to face consultation that reflects demand, clinical appropriateness and service efficiency.

3.4.2 For the primary care assessment unit the following hours of operation will apply:

- the period beginning at 12 noon on any day from Monday to Thursday and ending at 8 am on the following day;
- the period between 12 noon on Friday and 8 am on the following Monday; and
- Good Friday, Christmas Day and Bank Holidays;

3.4.3 For additional out-of-hours treatment centres based within alternative community settings the following hours of operation will apply

- the period beginning at 6.30pm on any day from Monday to Thursday and ending at 8 am on the following day;
- the period between 6.30pm on Friday and 8 am on the following Monday; and
- Good Friday, Christmas Day and Bank Holidays;

3.4.4 The hospital at home service will operate as a 24/7 service and only health professionals can refer to this service. Patients will not be able to self-refer

3.4.5 The service will meet local needs for West Kent, be easily accessible for patients, particularly those who are vulnerable and/or disadvantaged. Access must be simple, consistent and provided to meet the needs of all patients, including those who are vulnerable, have special needs, whose first language is not English, and who have impaired hearing (as per the National Quality Requirements). Facilities must be accessible to patients with mobility problems or physical disabilities. The service must also demonstrate its equity in terms of access for culture, gender, age, sexuality, faith and ethnicity

### 3.5 Management of referrals

#### 3.5.1 The provider must:

- Receive details of callers from the NHS 111 call-handling service where definitive clinical management or a face to face visit is required and respond

appropriately

- Receive calls from other services and health professionals (such as the ambulance service or district nursing when they are on site with a patient for whom:
  - immediate transport to hospital is not appropriate,
  - the health professional wishes to arrange care during the out of hours period,
  - the health professional wishes their patient to be assessed for hospital at home.

The provider will work towards greater integration of the service with the NHS 111 provider covering the call-handling so that most appointments and home visit can be arranged and confirmed efficiently and speedily for the patient. This requires direct booking by the NHS 111 service so that the majority of calls are closed with the patient knowing if and when they are to be seen face to face.

If the presenting clinical need requires a GP consultation, the 111 service will refer the patient to the out-of-hours service for a telephone assessment, a face to face visit either at an out-of-hours designated treatment centre or within the patient's own home, whichever is considered most appropriate. The pathway for patients between NHS 111 and out-of-hours will be in accordance with nationally determined protocols and will require agreement and sign-off through the NHS 111 Governance Board. A single telephone number will be required by the provider so that the NHS 111 Service, A&E, Urgent Care Centre, GP, ambulance and other interested professionals can make contact to update the service on an individual patient's progress.

The service must have clinically safe and effective systems for responding to calls already prioritised by the NHS 111 service which must comply with the National Quality Requirements

Referral protocols must be in place with NHS 111 providers, setting out the arrangements for passing data and transferring responsibility for the care of the patient. The aim is to maximise understanding within the receiving service and minimise the need for the caller to repeat details.

The Provider must develop arrangements with the NHS 111 service to facilitate the NHS 111 service making referrals for patients who require: to talk to a GP; a face to face consultation either at home or at the designated treatment centres.

If the NHS 111 service or other referring professionals were unable to complete the definitive assessment the service must:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient details being received from NHS 111, or from any other interested party such as the Ambulance Service or the patient's GP.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient details being received either from NHS 111 or another referral point.

The Service must meet the response times of:

- Emergency within 1 hour.
- Urgent within 2 hours.
- Less urgent within 6 hours.

### **3.5.2 Referrals to the hospital at home service**

Response/contact will be within 2 hours of the referral being made if the need is medically urgent. However the response time must be one hour for acute urinary retention and Hypoglycaemia.

Referrals can be made through health and social care professionals in accordance with the eligibility criteria which would include GPs, SECAMB and 'Out of Hours' Service. The Provider will inform the patient's GP of the referral

Each accepted referral will have an allocated senior nurse practitioner who will remain with the service user/patient throughout the episode and will lead the review that will lead to discharge from the service (which may include reinstating previous packages of care)

Unregistered patients living in the area will access the service in the same way as registered patients. Following treatment, the provider must encourage unregistered patients who present at the service to register with a local practice by providing a list of relevant practices within an accessible geographical area encompassing the patient's postcode.

If the patient is not ordinarily resident in the UK there may be a charge for this service. The provider will have a system in place to support this process.

### **3.5.3 Referrals to the Ambulance Service**

The provider will implement robust processes, protocols and systems to automatically transfer life threatening calls to 999 services and ensure that patients do not have to make a 999 call.

The provider needs to have in place arrangements with the ambulance service to make sure:

- There is support to an ambulance crew on request if the presenting case is deemed appropriate for primary care treatment/advice.
- The 999 crew will have the ability to refer and transfer to the Service, whenever this is clinically appropriate.
- The Provider must enable direct and easy referral from clinicians triaging or seeing patients to urgent ambulances.
- The Provider will have systems in place to receive referrals through alternate care pathways from Seacamb where clinically appropriate.

### **3.5.4 Transition time**

Transition time is a 30 minute period immediately prior to or immediately after the out-of-hours service hours. The provider will make arrangements to ensure that these transitional times are covered and that the patients are either treated or signposted, or that their care is transferred appropriately within these transitional

times.

The provider will ensure all referrals made between 1800h and 1830h are deemed appropriate for the service and are picked up and managed appropriately.

The provider will make arrangements to ensure that all patients referred between 0730h and 0800h have the episode of care completed and those episodes that remain open are transferred to the appropriate suitably qualified clinician.

### **3.5.5 Transfer of care**

The provider will have a policy and protocol in place to outline the expectations of definitive clinical management and face to face consultations. A GP is the most appropriate professional to supervise this.

The provider will ensure that there is a robust system for the process of the transfer of care or onward referral that satisfies the following conditions:

- The patient is able to understand and navigate the system without unnecessary delays or further need for advice.
- Information on the patient's personal details and clinical assessment is transferred to other services, such as urgent care centres, walk-in centres, acute trusts, mental health services, social services and other such services as deemed appropriate. This must be in accordance with the CCG's enhanced discharge summary policy.
- The provider will ensure that the following information is transferred:
  - Patient personal details, include where appropriate details of carer, next of kin or authorised representatives
  - Time and day of completed clinical consultation either by phone or face to face
  - Details of the suitably qualified clinician who provided the patient's care.
  - Summary of medical history and where appropriate, examination and investigation.
  - Diagnosis (primary and secondary).
  - Treatment provided: Dose, route, frequency and amount.
  - Final disposition
- The provider will have a system in place to assure itself that the information transferred has been received

The provider will supply full clinical details of any telephone advice, face to face consultations or home consultations to the GP by 0800h on the next working day either by fax or electronically (as per National Quality Requirement 2)

### **3.6 Case Management and Patients with Special Needs**

The Provider is expected to work with local GP practices to identify and meet the urgent needs of patients with long-term conditions, those receiving packages of continuing care, palliative care patients, frequent callers, and other patients with special needs.

In order to achieve this, the provider will:

Make arrangements with GP practices and other services in order to set up registers of patients under special care/case management arrangements or other patients with special needs, highlighting monitoring arrangements, care plans and other clinically appropriate information following requirements set out in coordinate my care

Any child or adult safeguarding issues should be referred to the appropriate service and reported immediately in accordance with the commissioner's safeguarding procedures to the named leads for safeguarding and the GP informed immediately, or at the latest on the next working day.

Liaise with local community nursing services and therapy teams such as case management, early intervention teams, etc.

Ensure that contacts with any such patients are fed back to their GP (or appropriate service provider) electronically by 0800h the next day.

Work with the NHS 111 provider to ensure the delivery of Coordinate my Care as part of the London wide pilot of NHS 111.

### **3.6.1 End of Life Care**

The provider will ensure its clinicians are familiar with and adhere as closely as is reasonably possible with the West Kent Care Pathway for palliative and end of life care. The Provider will make all necessary arrangements to work closely with the patient's GP practice and other relevant services to ensure that patient and their family are fully supported.

The Provider must:

- Work in partnership with local providers of end of life care to ensure that they have processes in place to access the most up-to-date information about vulnerable patients, their needs and preferences.
- Have systems in place to ensure that where possible the identified needs and expressed preferences of patients at the end of life, including preferred place of death are recorded and addressed.
- Patients at the end of life have access to timely and adequate medicine as agreed with the palliative care formulary and equipment, e.g. syringes drivers and catheters.
- Ensure all clinicians receive relevant training in end of life care to ensure patients are appropriately managed, within an agreed care pathway and where possible enabled to remain at home. The organisation must have systems in place and suitably qualified staff to undertake verification of death.
- Have a clear system of receiving and acting on information from patients' GPs, for example having a special case notes system and ensuring that it is used

### **3.6.2 Mental Health**

The Provider will work closely with the local mental health trust and social services in offering appropriate clinical input to mental health assessment and referral for

identified patients.

The arrangements for a patient with acute mental health needs being referred to the acute psychiatric services must be agreed between the provider and the local Mental Healthcare Trust prior to service commencement date.

### 3.7 Population covered

For the purposes of out of hours primary care the *Commissioning fact sheet for clinical commissioning groups*, NHS Commissioning Board, October 2012 states the following:

CCG's are responsible for commissioning *Out-of-hours primary medical services (for everyone present in your area)*, except where this responsibility has been retained by practices under the GP contract.

This means therefore that the service is for the resident, registered and unregistered population of West Kent.

### 3.8 Any acceptance and exclusion criteria and thresholds

NHS 111 service will undertake the initial clinical assessment of the patient and determine the outcome of that process.

Acceptance criteria for patients triaged through the A&E primary care stream are that the patient has been triaged to minors and is presenting with one of agreed list of conditions for treatment in the "primary care stream". These include, though are not exclusive to:

- Dermatology
- ENT (except direct ENT referrals)
- Respiratory (this will include coughs, colds, hayfever, asthma, chest infections etc.)
- Gastro-intestinal (abdo pain, constipation, gastroenteritis etc.)
- Back pain (Non-traumatic)
- Limb/joint problems (Non-traumatic)
- Genito-urinary presentations.
- Ophthalmology (Non-traumatic)
- Headaches and dizziness
- Paediatrics (Non-traumatic)
- Gynaecology (not attending EGAU)

Exclusions (These patients should have been triaged to Majors)

- Grossly abnormal observations
- Potential for serious illness or injury

Acceptance criteria for patients referred to hospital at home service are that they are diagnosed with one or more of the agreed schedule of clinical conditions:

- Cellulitis not responding to oral antibiotics
- UTIs without sepsis but causing other morbidities like falls or acute

confusion.

- Stable Community acquired pneumonia needing iv antibiotics/ hydration or monitoring (detail guidance to be further worked out)
- COPD and asthma exacerbation
- Acute heart failure (mild to moderate)
- Non fracture Falls
- Dementia crisis
- Acute confusion
- Gastroenteritis with mild to moderate dehydration
- Hypoglycaemia in patients on Insulin
- Frail Elderly with acute loss of self-independence or mobility due to any minor illness.
- Acute urinary retention (needs linking with urgent urology OPD slots and adhere to the Community catheter pathway)
- Palliative or end of life care with acute deterioration
- A person who is experiencing a sudden level of reduced mobility and ability to self-care.
- A person who is recovering from injury or surgery.
- A patient fit for discharge, but for the need to complete IV antibiotics.
- Patients who have lines and require a course of IV antibiotics (e.g. bronchiectasis).
- Patients with high level tube feeding needs beyond the scope of the regular community nursing team.

The above list of conditions may be expanded as the service develops.

### **3.9 Interdependence with other services/providers**

The provider shall work jointly with existing services including Primary Care, SECAMB, Kent and Medway Partnership Trust, Maidstone and Tunbridge Wells NHS Trust, Kent Community Health Services, Kent County Council and the voluntary and community sector.

This will include working closely with paramedics, medics, LTC nurses, specialist nurses, community hospitals, social services reablement teams, the intermediate care team, the Romney ward, Health and Social care co-ordinators, the community falls service, the Carers Assessment and Support Service, community geriatricians, integrated multi-disciplinary teams, dementia and EOLC crisis services

Electronic discharge information shall be communicated by the Contractor to GPs within twenty four (24) hours

Pathways used by the contract shall include all sectors including the voluntary sector

The contractor shall develop strong links with social services in-hours and out-of-hours services in order to provide continuity of care to Patients with social care needs

## 4. IT Requirements

The Health and Social Care Act 2012 is driving radical changes to way care is provided. To be able to achieve this, clinical providers are required to:

- Provide interoperability between their clinical systems and systems operated by other care providers. This includes, but is not limited to, GPs, clinical care providers, social care providers and cross-provider systems commissioned by the CCG. Such systems are expected to include access for patients / carers;
- Provide enhanced data to the CCG for, but not limited to, analysis of performance, care design and commissioning;
- Use any cross-provider systems that are necessarily commissioned by the CCG;
- Move to a fully paperless environment by 2018 (NHS England timescales) but make material progress towards this in 2014/15.

This applies to existing clinical systems, replacement clinical systems and any new clinical systems.

### 4.1 Further Detail of the Requirements

Definitions:

#### 4.1.1 In the following paragraphs:

- 'Clinical systems' means the systems that are used by the provider to plan or provide patient care, upon which the provider creates / records / manipulates patient data. This does not include systems used by the provider to manage their business operations (e.g. finance systems);
- 'Interoperability' means interconnection of systems to exchange data, delivery of data in a usable format and possible modification of computer systems to create or make use of the data exchanged.

#### 4.1.2 Requirements for interoperability:

- Providers are required to interconnect their clinical systems with other care providers in the health and social care system; the list of care providers will be defined by the CCG and will be added-to throughout the year;
- Providers are required to use interface approaches defined by the CCG; the interface approaches will use the standards being defined within health and social care where available (e.g. the Interoperability Toolkit definitions);
- The approaches will define all aspects of the interface including, but not limited to, the data to be transferred, the format of the data, the time for data transfer (including real-time), the availability of the data (in terms of hours in the day), the data transfer media / protocols, and the metadata;
- The interface definition may define which technologies should be used for the data transfer including, but not limited to, interface hardware, interface software, technologies for security, and data compression;

- Interoperability may require the provider to make changes to existing clinical systems to increase the level of integration and usability of exchanged data;
- The exchange may include two-way transfer of data with the ability to update providers' systems by a patient / carer or user outside the provider;
- The data to be transferred will include both patient confidential data and data for secondary use;
- The transfer may be required to go via a third party who may also be used to pseudonymise or anonymise data that is for secondary use;
- Information Governance rules will apply at all times.

#### **4.1.3 Requirements for maintaining interoperability**

- Providers are required to maintain their interfaces within defined timescales to accommodate any changes within the wider health and social care system and to continue the delivery of data if the provider changes their own systems;
- Providers are required to test that their interfaces are 'fit for purpose' and ensure that the interfaces do not introduce any errors in the data;
- Providers are required to ensure continuity of availability of data through defined and regularly tested business continuity and disaster recovery arrangements;

#### **4.1.4 Requirements for provision of enhanced data to the CCG:**

- Providers are required to provide data to the CCG for, but not limited to, analysis of performance, care design and commissioning;
- The data required will be defined by the CCG and will include information required by the national health and social care bodies, and data required by the CCG;
- Providers may be required to capture and record additional data, not currently available today, that is deemed to be necessary for development of health and social care and meeting the needs of the Mapping the Future programme;
- The data definitions will define all aspects of the data including, but not limited to, the data to be transferred, the format of the data, the time for data transfer (including real-time), the availability of the data (in terms of hours in the day), the data transfer media/protocols, and the metadata;
- Providers are required to ensure that the data is 100% accurate, 100% complete and delivered to agreed timescales or in real-time;
- The data to be transferred will include both patient confidential data and data for secondary use;
- Providers may be required to pseudonymise or anonymise data that is for secondary use before exchange;
- The data may be required to be sent to a third party who may also be used to pseudonymise or anonymise data that is for secondary use;

- Information Governance rules will apply at all times.

#### **4.1.5 Requirement to use cross-provider systems that are necessarily commissioned by the CCG.**

These include, but are not limited to, care plan management systems and continuing health care systems:

- The CCG will commission these systems where it is appropriate to do so;
- Providers are required to use these systems if they are involved in the care that the systems manage;
- The CCG will endeavour to interface such systems to providers' existing systems but this may not always be doable.
- Move to a fully paperless environment by 2018 (NHS England deadline). Achieving this requires providers to:
  - Use electronic transfer for all data exchange with patients / carers, GPs, other providers and other stakeholders;
  - Extend the reach of systems to devices for mobile staff so there is no need to carry paper documents and data is available / captured at the point of use;
  - Implement security on mobile devices to meet Information Governance rules.

#### **4.1.6 In 2014/15, providers are required to:**

- Develop realistic plans for achieving this and share the plans with the CCG;
- Make material progress towards a paperless environment within the 2014/15 financial year so that the programme of work can be delivered in advance of 2018.

## **5. Applicable Service Standards**

### **5.1 Applicable national standards (e.g. NICE)**

5.1.1 The Provider must comply with:

- Care Quality Commission Standards
- Relevant pathways, NICE and National Standard Framework (NSF) guidance and ensure clinical audits take place
- The revised hygiene code, The Health and Social Care Act 2008, Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance;
- Relevant standards to assure safeguarding of vulnerable adults
- Ensure all staff in contact with, or accessing data about, vulnerable adults have enhanced CRB checks
- Adhere to the Commissioner's procedures, protocols and guidance on Adult Protection
- Embed learning's from Serious Untoward Incidents into internal procedures

and protocols

- Adhere to the requirements of the Mental Capacity Act 2005 (amended 2007)

5.1.2 The Provider must comply with the following regulations and legislation:

- Equal Pay Act 1970
- Sex Discrimination Act (as amended) 1975
- Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)
- Disability Discrimination Act 1995 (as amended) 2005
- Human Rights Act 1998
- Sex discrimination (Gender Reassignment) regulations 1999
- Employment Equality (Religion and Belief) regulations 2003
- Employment Equality (Sexual Orientation) regulations 2003
- Gender Recognition Act 2004
- Age Discrimination Regulations 2004, and
- Equality Act 2006 (Gender Equality Duty)

## 5.2 **Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

## 5.3 **Applicable local standards**

### **5.3.1 Staffing**

- The Provider/s must have in place a detailed staffing plan that describes the staffing arrangements that will enable the delivery of the services for the duration of the contract.
- The Provider/s must ensure there is a staff conduct policy which covers inappropriate behaviour and customer care.
- The Provider/s must have an appropriate range of HR policies (including, but not limited to, policy for recruitment, performance, appraisal, disciplinary issues, staff grievances, alcohol and substance misuses, etc).
- The Provider/s must have appropriate Occupational Health procedures including, but not limited to, procedures to check that staff are fit to carry out all duties safely.
- The Provider/s must ensure all staff are aware of the procedure for reporting incidents.
- All staff must have a good standard of English in order to clearly communicate with attendees. This needs to be in line with current legislation and good practice.
- All staff must be trained in and adhere to the NHS Information Governance

requirements.

- All staff with access to patients or patient related information must have a current CRB check (at an appropriate level as defined by the Home Office) which must be made available upon request to the Commissioner.
- Staff must also have an identified mentor who will support them in their role to ensure high quality services are provided

### **5.3.2 Training**

All staff are provided with appropriate training to enable them to carry out their duties with due diligence. Training includes:

- Manual Handling
- Risk Assessment
- First aid
- Infection prevention and control
- Incident reporting and management
- Safeguarding
- Promoting independence

### **5.3.4 Communication**

- Authorised Officers and contact points must be identified in the contract for Commissioner.
- The Provider/s staff must have a proactive, friendly, solution-focussed style of communication. A key objective is to have high-quality communication to discuss flexible and innovative approaches.
- The Provider/s must gain patient and staff feedback and demonstrate evidence of improvement in service in line with the feedback, surveys and complaints.
- The Provider/s must ensure that procedures exist for handling complaints in line with the Commissioner's complaints procedures.
- The Provider/s must inform the Commissioner of any Serious Incidents.
- The Provider/s must ensure the Commissioner is made aware of any actions that could impact on service delivery or publicity.
- The Commissioner will ensure the Provider/s is made aware of any actions that could impact on service delivery or publicity.

### **5.3.5 Management Structures**

The Provider/s must ensure that there is an appropriate organisational structure to provide services to the levels specified in this Contract.

Contact details of the designated staff must be made available, i.e. names, titles, email addresses and telephone numbers. This shall be updated should this information change.

The Provider/s is expected to be proactive to ensure the organisation is a good place to work. This includes setting internal Key Performance Indicators and encouraging staff feedback through formal and informal feedback.

### **5.3.6 Information Governance**

The Provider/s must use an Information Technology solution which will deliver the Information and Security Management requirements of the contract

The Provider/s is responsible for:

- The provision and management of IM&T hardware and software. Systems should use the N3 network, utilising fast broadband, secure networking services which are interoperable with the Commissioners' and other stakeholders' systems.
- Ensuring that appropriate information management and governance systems and processes are in place to safeguard patient information and to comply with confidentiality and Data Protection laws/regulations and Confidentiality Codes of Practice and all other requirements as defined by Department of Health. This must be supported by appropriate training for all staff. All information must be secure in any form or media, such as paper or electronic system. Any exchange of personal/sensitive data must be via an appropriate secure method/process.
- Ensuring full detailed information is available for performance management, audits, prevention of fraud and investigation of any complaints.

All staff must respect the confidentiality of any information relating to the Commissioners, their staff or patients.

### **5.3.7 Sustainability and Carbon Management**

The Provider/s must have a Sustainability policy which underpins their service design.

### **5.3.8 General Policies**

- The Provider/s must comply with all current legislation and policies.
- The Provider/s must comply with all procedures related to all Serious Incidents and Patient Safety Incident reporting.
- The Commissioner requires the Provider's staff to operate a no smoking policy.
- The Provider/s must demonstrate that action has been taken to reduce patient / staff inequalities.
- The Provider/s must comply with Commissioner Safeguarding Children and Adults in Vulnerable Circumstances.
- The Provider/s must have an appropriate range of health and safety related policies including, but not limited to, health and safety, first aid, risk assessment/management and business continuity.

### **5.3.9 Marketing of this service**

The provider/s will support the commissioners to advertise this service across West Kent

## **6. Applicable monitoring and quality requirements and CQUIN goals**

### **6.1 Monitoring Requirements**

6.1.1 The CCG will collate and circulate performance information. Performance data will be provided to the Operational Group of the Urgent Care Board, which will be responsible for monitoring performance against the service specification.

6.1.2 It is expected that the provider will attend the Operational Group of the Urgent Care Board, when required, to update the group. It is expected that this will be no more than two times a year.

## 6.2 Applicable Key Performance Indicators

6.2.1 Robust and accurate monitoring information will be reported monthly as detailed below;

- Age
- Gender
- Ethnicity
- Disability
- GP and GP practice code
- Total number of referrals broken down by
  - Time, date and day of referral
  - Service stream (primary care: telephone, base or home visit & hospital at home)
  - Source of referral
  - Reason for referral
- Impact on patient flows (A&E waiting times)
- A&E staff satisfaction
- Discharge date
- Discharge destination (for example GP, community falls service, acute, Romney ward, rehabilitation, reablement, social services, mental health, voluntary services, hospice)
- Total management days provided to the patient,
- Diagnostics undertaken
- Diagnosis, including secondary diagnosis (including if ambulatory care)
- If the referral was rejected, rationale for why the referral was rejected and onward referral made
- Response time for assessment and treatment
- If the treatment was or was not completed and rationale if treatment was not completed
- Prescribing undertaken and drugs dispensed
- Number of people supported to have a good death in their usual place of residence

6.2.2 The provider will be required to support the CCG to carry out an annual audit / case note review in order to track and trace patients to review their longer term outcomes and the services impact on hospital admissions.

6.2.3 For patients seen through the primary care assessment unit the provider will be required to support the CCG to carry out an audit of a selection of case notes to

assess the effectiveness of the service:

- Mean length of time of patients in the department
- Number of patients referred to specialty teams
- Number of patients admitted to hospital
- Number and type of pathology tests ordered
- Number and type of radiology tests ordered
- Medications / fluids administered whilst in department
- Medications given to take home

### 6.3 Applicable quality requirements (See Schedule 4 Parts A-D)

- Safeguarding issues, near misses, incidents and Serious Untoward Incidents (SUI's)
- Complaints, compliments
- C Difficile reporting
- Patient satisfaction and patient reported outcome measures. Specifically satisfaction with service, satisfaction with staff, understanding the service, and patient reported measures of improvement.

### 6.4 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

## 7. Location of Provider Premises

The Provider's premises will be co-located at Maidstone Hospital and Tunbridge Wells hospital's A&E departments.

Co-location within additional community sites maybe identified by the provider as beneficial in order to meet the needs of patients and improve integration and working arrangements with other services

## 8. Individual Service User Placement