Title of Scheme	The Future of Local Health Services in Northern Staffordshire
CCGs covered by the scheme:	North Staffordshire CCG & Stoke-on-Trent CCG
Commissioning Lead for scheme:	Head of Strategic Commissioning
Senior Manager/Executive Sponsor:	Director of Strategy, Planning & Performance

1.0 Brief description of scheme:

The health and social care needs of the North Staffordshire and Stoke-on-Trent population are changing. People are living longer with increasing long-term conditions, requiring ongoing support and management. This is putting a significant strain on our services and the sustainability of health system.

Given these pressures, we need to think differently about how we provide services closer to home, and in particular for adults with high clinical needs (such as multiple long term conditions and/or significant frailty) who are at risk of unnecessary or inappropriate admission to acute hospitals. Our community hospitals provide both bed based services and wider non-bed based services including outpatient care, minor injuries, day case and, x-ray. Our focus is on ensuring the greatest health benefit from these resources which will allow patients to manage their own conditions and access care from home. We are engaging with the public and local stakeholders to develop proposals to meet these aims, including what the future role of our community hospitals and associated services should be.

The draft model of care we have developed for our community services aims to meet the needs of the local population and deliver the right care in the right setting. This is consistent with the NHS Five Year Forward View, the GP Five Year Forward View and the Five Year Forward View for Mental Health. We believe the range of services within our communities, including community hospitals, can make a significant contribution to the development of new local care models. This should lead to better outcomes for patients and provide more sustainable services. The clinical case for change along with the viable solutions to the problems described are clearly articulated in the Pre-Consultation Business Case (PCBC) which has been developed with clinicians, providers, patients and other key stakeholders.

The default care setting for all elderly patients should be the place they call home. Our local engagement has told us that this is not only what people want but it can also improve outcomes and be a more effective use of available resources.

Historically, the number of beds within Northern Staffordshire has led us to a position where patients have been cared for at a level higher than required to meet their needs. This is not an efficient use of resources and also leads in many cases to a longer length of stay and a higher likelihood of entering long term care.

It is, however, acknowledged that some patients upon discharge will have needs that place them beyond the thresholds to be cared for safely at home. The CCGs will continue to commission a significant number of beds to support patients requiring a higher level of care and/or requiring an assessment for longer term 24 hour care needs. These beds will be commissioned in line with the clinical need of this cohort of patients.

The integration of services and a flexible workforce will support the maximisation of capacity within the community and will reduce the numbers of handoffs between services therefore positively impacting upon individual patients' experience

Through the new model of care patients will receive the right level of support, by an appropriately skilled workforce, in a timely way and for a time limited period. The model will also maximise independent living and actively support people to return to optimal levels of functioning.

There are a set of key principles that sit behind the implementation of providing care closer to home as outlined below:

- The model will be based upon a pull by community not push by acute;
- Clinical governance will sit with the community provider;
- No assessments for on-going care needs will carried out in an acute bed (unless by clinical exception);
- The full implementation will ensure that more people go home with a reduction in the number of patients going into a bed based rehabilitation service; and
- Pathways and principles across Northern Staffordshire will be aligned to ensure equity of provision.

The PCBC focusses on community-based services across North Staffordshire and Stoke-on-Trent. Specifically, the proposed way forward for community-based care covering:

- The bed configuration for community services Adult Intermediate Rehabilitation Service Beds (AIRS beds); and
- Our proposals to integrate and expand existing wider community services into Integrated Care Hubs.

This quality impact assessment has therefore been separated into two sections to mirror the proposed changes.

2.0 Intended Quality Improvement Outcome/s:

There is consensus across North Staffordshire and Stoke-on-Trent that if we do not redesign and transform services to improve quality, using the available resource as efficiently as possible, our population will experience poorer health outcomes as a direct result.

Caring for elderly patients in the place they call home can greatly improve the quality of care received and the outcomes achieved. Evidence suggests that caring for older people in a hospital bed can often outweigh the benefits of care received due to decompensation.

The NHS Emergency Care Improvement Programme (ECIP) reported that the negative impact of bed rest in older people is as follows:

In the first 24 hours:	In the first 7 days:
• Reduction in muscle strength of 2-5%; • Reduction in circulating volume by up to 5%;	• Reduction in circulating volume by up to 20%; • Loss of muscle strength 5-10%; • Reduction in functional residual capacity (FRC) of 15-30%; • Negative impact upon skin integrity

Two separate studies[1] have shown that 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.

The overall aim of the Integrated Care Teams is to improve outcomes for people, create access to better, more integrated care outside of hospital, reduce unnecessary hospital admissions and enable effective working of professionals across individual Care Hubs.

- Support for General Practice and the extended primary care team in the management of patients with Diabetes, Heart Failure and Respiratory conditions that makes patient care excellent and delivers individual patient outcomes in line with their management plans aligned with the new models of care.
- Specialist integrated team knowledge and skills to impact positively and be evident in the care plans for patients being case managed.
- Patients and the families of patients approaching the end of life are cared for in line with their wishes in their preferred place of care.
- Specialist teams contribute to and are active in the delivery of the single care plan.
- Identify and implement practices that empower patients so that they identify themselves as feeling confident to manage their long term condition(s) including an increase in number of patients who identify themselves as feeling confident to manage their long term condition,

3.0 Methods to be used to monitor quality impact:

The West Staffordshire Urgent Care Board will monitor the impact on the health economy's urgent care system. Revised service specifications for Home First and Integrated Care Services will be outcome focused and a number of quality requirements and key performance indicators will be developed to ensure that quality and safety of services are not compromised. This information will be monitored at Clinical Quality Review Meetings in accordance with the CCG's Quality Strategy and reported to contract monitoring meetings which are responsible for monitoring performance against the service specifications.

4.0 The bed configuration for community services Adult Intermediate Rehabilitation Service Beds

Historically Adult Intermediate Rehabilitation beds were provided from 5 community hospital – Bradwell, Cheadle, Haywood, Leek Moorlands and Longton Cottage; providing a capacity of 264 beds. Since 2015 a number of the

[1] Gill et al (2004) studied the association between bedrest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity. & Kortebein P, Symons TB, Ferrando A et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontal A Biol Sci Med Sci. 2008;63:1076-1081

rehabilitation beds have been temporarily closed and additional capacity has been commissioned in the care home setting; providing a capacity of 132 beds. During this period the clinical model has iteratively changed developing both the home first model – providing reablement care in people home/care home – and significantly increasing the hours of community care by 25%.

The options contained within the Pre Consultation Business Case based on a sustained change to the clinical model all maintain a capacity of 132 beds. Following discussion at the Expert Panel held on 12th June 2018 the 'provisional preferred option' to allow a flexible bed capacity based upon patient need was Option 1 – Haywood & Care.

Area of Quality Beds	Impact Questions Could the proposal impact positively or Negatively on any of the following?	Description of Impact (Positive /negative/Unchanged) & Rationale	Risk Rating L C R	Mitigation Strategy & Monitoring Arrangements
DUTY OF QUALITY	○ The duty to secure continuous improvement in the quality of the healthcare commissioned (Health and Social Care Act 2008 Section 139)?	Positive. CCGs set out their expectations of outcomes, quality standards and planned monitoring arrangements through contracts with providers. Prior to any changes to commissioned services, service specifications and outcome focused key performance indicators will be revised and standardised. The CCGs will commission Midlands Partnership NHS Foundation Trust (MPFT) as the lead provider for all community beds including any care home provision. The monitoring of community beds (including care homes) will take place through a new additional subgroup of MPFT's Clinical Quality Review Meeting. This will allow focused discussion of disaggregated information specific to the proposed changes. Learning from experience, as part of any procurement exercise to award subcontracts with care homes, joint (CCGs, MPFT, and local authorities) announced and unannounced site visits will take place prior to any contracts being awarded. The CCG will only allow MPFT to subcontract to care home providers with a CQC rating of 'Good'. The quality monitoring of care homes of care homes in general (where the CCG does not have a contract in place) is undertaken by the relevant local authority. There are 147 care homes in North Staffordshire & Stoke-on-Trent. Those homes that have been inspected by the CQC have been rated as follows: 1 'Outstanding', 94 'Good', 40 'Requires Improvement' and 2 'Inadequate'. Pan-Staffordshire CCGs are working in partnership with Staffordshire County Council & Stoke-on-Trent City Council to support quality	Pre-existing risk on CCG's risk register: 3 x 3 (Amber)	Future procurements will formalise current incentivised agreements with care homes to increase staffing to support 7 day admissions. Should the CCGs be required to commission short term (unexpected surge) care home bed capacity based on patient need, the CCG will utilise a dynamic procurement system (ADAM) to procure the beds. The ADAM system is currently utilised by continuing healthcare to appropriately procure placements based on the patient's care needs, taking into account known quality outcomes, admission restrictions, etc.

Area of	Impact Questions	Description of Impact (Positive /negative/Unchanged) &	Risk Rating	Mitigation Strategy &
		monitoring and improvement within care homes including an 'Improvement & Responsive Team'. Forums to share information take place monthly at the CCG led Nursing Home Quality Assurance & Improvement Group and local authority led Quality & Safeguarding Information Sharing Meeting. Staffordshire County Council and Staffordshire CCGs have developed the 'Provider Failure Standard Operating Procedure' which sets out procedures and responsibilities for meeting the needs of patients in the event of a closure of a care home.		
	○ Commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution? ○ Strategic partnerships and shared risk?	Unchanged. Demand and capacity modelling utilising UHNM exit strategy plans for complex discharges (e.g. where clinicians wanted to discharge the patient to based on need) and assuming an occupancy level of 95% (to allow for flexibility and surge) has been undertaken and signed off by health economy stakeholders of the West Staffordshire Urgent Care Board. The proposed modelling which delivers the shift required from bed based capacity to home based capacity, 132 beds (77 intermediate/reablement and 55 assessment), is based upon achieving a 70% target for patients going home with 30% transferring to a community hospital or care home bed dependent upon their needs. Within the Home First Model the average wait for people to be moved from acute services at the hospital to their home setting is currently 1 day. Patients are not moved into another bed in the interim which avoids unnecessary disruption to these patients and their recovery. Further, over time the unmet demand for North Staffordshire and Stoke has reduced from 109 patients equating to 456 bed days lost on 2/11/2017, to 84 patients equating to 252 bed days lost on 22/2/2018, to 66 patients equating to 151 bed	Pre-existing risk on CCG's risk register: 4 x 5 (Red)	However, the CCG retains a Red Risk on its risk register concerning the potential impacts of urgent care performance pressures on patients (risk rating reflected in previous column). It is recognised that it is likely that increased community bed capacity will be needed at various points, both due to demographic and non-demographic growth and any unpredicted surge in demand. It is proposed that additional escalation capacity be made available to ensure flexible reaction to predicted surge (e.g. winter planning) and unexpected surge.

Area of	Impact Questions	Description of Impact (Positive /negative/Unchanged) &	Risk Rating	Mitigation Strategy &
		days lost on 7/6/2018.		
	○ The duty to protect children, young people and adults?	Positive. Since September 2016 the CCGs have commissioned community beds within care homes. During this period three homes have come under the Large Scale Enquiry procedure due to concerns about the care delivered. The CCGs were a partner in the multi-agency response on both occasions. Our main learning from these occasions has been an increased awareness of the gap in professional leadership expertise locally within the care home sector, to support staff within the homes with care planning, assessments and delivery. To address this gap and strengthen local support, the CCGs will commission MPFT as the lead provider for all community beds including any care home provision. MPFT will be responsible for the management and the clinical and therapy input into the commissioned bed base under the D2A pathway and will also provide medical oversight into the beds. In addition, and learning from experience, MPFT will also provide clinical leadership, have responsibility for ensuring that robust staffing models are in place over seven days and that care is delivered to the standards set out within the service specification. This will ensure that all community beds are subject to the same clinical governance arrangements and oversight. Due to the layout of the wards within the community hospitals the beds are not suitable as placements for patients with EMI nursing assessment needs. Specialist nursing homes with the relevant expertise provide the best environment for the care of this cohort of patients.	N/A	N/A
	○ Tackling health inequalities and focusing resources where they are needed most?	Unchanged. Implementing the Home First Model the CCG will commission community services based on patient need. The CCGs have increased community care hours by 125% to 6,200 at any one time allowing 413 patients to be supported.	N/A	N/A

Area of	Impact Questions	Description of Impact (Positive /negative/Unchanged) &	Risk Rating	Mitigation Strategy &
		A separate Equality Impact Assessment (EIA) has been undertaken by the CCGs which will be reviewed following the completion of formal consultation in January 2019. The EIA incorporates substantial engagement with a range of stakeholders and the public. Further, a stakeholder mapping exercise was undertaken with the Local Equality Advisory Forum (LEAF) on 23rd May 2018 to inform the Consultation Plan. This was cross referenced against the CGC's database of organisations representing the protected groups and will ensure that the appropriate organisations and individuals are consulted in an accessible and appropriate way that meets their needs. The main areas highlighted by the EIA for consideration are frailty and accessibility.		
EFFECTIVE	○ The implementation of evidence based practice? ○ Improvements in care pathway(s)? ○ Reduction of unwarranted variations in care? ○ Full adoption of Better Care, Better Value metrics?	Unchanged. NHS Five Year Forward View, NHS England, 2014 High impact change model: Managing transfers of care between hospital and home, NHS England, Local Government Association, 2015. NICE Guideline 27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs, 2015. NHS England's Quick Guide: Discharge to Asses and benefits for older, vulnerable people.	N/A	N/A
	○ Clinical leadership? ○ Clinical engagement?	Unchanged. The CCGs, led by the CCG's Medical Director and Clinical Director, have undertaken clinical engagement with the GP Federation, Northern Alliance Board, GP Members and West Midlands Clinical Senate. Feedback has been incorporated into the development of the Pre Consultation Business Case.		

Area of	Impact Questions	Description of Impact (Positive /negative/Unchanged) &	Risk Rating	Mitigation Strategy &
	○ The ability to review quality improvements through core clinical quality indicators supported by good information?	Unchanged. Refer to 'duty to secure continuous improvement' above.		
	○ Promotion of self-care?	Unchanged. The model of care is based upon clinical best practice and feedback from engagement events. Home is the preferred setting for health and care interventions. One of the key design principles is that people will self-care to live well and independently in their own homes and where they need support this will be provided by family, friends, community and public bodies in the health economy. Further, patients will feel empowered and self-care and management is promoted. Patients can make informed choices about their care and take responsibility for their own health and wellbeing through rehabilitation and supported self-management.		
EXPERIENCE	○ Self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)?	Unchanged. Throughout 2015 North Staffordshire & Stoke-on-Trent CCGs undertook extensive engagement on a new model of care, known as 'My Care, My Way – Home First', which aims to support patients to remain fit and well and supported within their own homes without the need for an admission to a hospital bed. The full report is available here: http://www.northstaffsccg.nhs.uk/my-care-my-way. The feedback from the public and other stakeholders was that patients benefit from being – and prefer to be – at home and support the proposed model of care in principle. However, stakeholders want: • Assurance that there is capacity in community services to support the model; • To be sure about the future of community hospitals; • Effective support for every spouse/family/carer; • To know it will be carefully implemented and patients will be followed up in the community; • To know the investment is in place to support the changes.	N/A	N/A.

Area of	Impact Questions	Description of Impact (Positive /negative/Unchanged) &	Risk Rating	Mitigation Strategy &
		Further engagement has reiterated the above findings and concerns around quality of care home quality of care.		
	○ Patient choice?	Unchanged. The decision of the requirement for a complex discharge is made by the discharging clinician(s). This process is not changed by the consultation.		
	○ Accessibility of services?	Unchanged. Analysis has been undertaken to consider the average change in patient travel time and distance from the current configuration of beds (with temporary closures in effect) and previous configuration (prior to temporary closures) across each of the six options. That is, we look at how long it would take on average a patient to travel to their closest site in the current and previous configurations (post and pre temporary closure) and compare this against what the time would be under each of the six options. Our analysis shows that on average, the additional average travel time across each options is less than 10 minutes – though this doesn't into account traffic conditions. This is not expected to have an impact on quality of care received. Though noting that we have to go through a process to procure care homes, the estimates show that if care homes were procured locally, there will be a more beneficial (smaller) change in travel time.		
	○ Compassionate and personalised care?	Unchanged. CCGs set out their expectations of outcomes, quality standards and planned monitoring arrangements through contracts with providers.		
SAFE	○ Patient safety and preventable harm?	Unchanged. During Multi-Agency Discharge Events (MADE) in in March & June 2018 point prevalence audits of patients within community beds (community hospital & care homes) have demonstrated that all of the 118 (March) and 101 (June) patients were appropriately placed within assessment beds e.g. all patients required an assessment of future need. This reduces the risk of deconditioning and exposure to healthcare acquired infections.	N/A	N/A
	○ Reducing healthcare acquired infections?			
	○ Clinical workforce capacity (recruitment & retention), capability and competency?	Unchanged. Nationally and locally workforce recruitment and retention remains a key challenge within both NHS and private providers. Health & social care partners in the	N/A	N/A

Area of	Impact Questions	Description of Impact (Positive /negative/Unchanged) &	Risk Rating	Mitigation Strategy &
		health economy are working together within the Sustainability & Transformation Partnership (STP) to address recruitment and retention in Staffordshire. In March 2018 22.58% of shifts at Community Hospitals were below the agreed staffing levels, 31% agency usage and limited success in recruiting to positions over a two year period. NHS Benchmarking concurs with local expert provider advice that an ideal ward size is 20 patients per ward (i.e. total of 40 allowing for male and female), with a good mix of side rooms and bays. This allows a good use of the area, a good staffing ratio, and allows for absences to be managed safely. Further, learning from local incidents a site should have a minimum of 2 wards to support flexibility to maintain safer staffing levels. Further, dependent upon the community hospital sites chosen there are environmental layout challenges which increase nurse/healthcare support worker numbers required to maintain safe staffing. Currently there is a pressure on primary care where care home beds are situated in multiple areas due to the requirement to provide medical support. Moving towards a reduced number of sites with clinical governance and oversight provided by MPFT.will strengthen the clinical model and reduce the impact upon primary care. Creation of the Home First Team has led to movement of staff from other community nursing staff. Whereby opportunities have been presented for staff to be promoted and move within the health economy. However, overall the need to recruit into the health economy remains.		

5.0 Our proposals to integrate and expand existing wider community services into Integrated Care Hubs.
The service will be delivered through localities and primary care hubs moving forwards under a multi-disciplinary approach, utilising risk stratification to identify those patients requiring proactive management and support across a team of specialist nurses, therapists, mental health professionals, pharmacists and social care professionals supported by the overarching governance of specialist consultants where required. The service will be led through strong clinical management within primary care. It is expected that the response to the requirements will be developed through the three Alliance Boards covering Staffordshire.

The service will support and integrate with wider community services in the timely and effective management of patients including district nursing, specialist nursing, specialist therapies, community matrons and social care provision. The team will where appropriate bring in the expertise and enhanced support of teams such as the Home First service to avoid inappropriate admission to secondary care and to support patients to remain independent at home for as long as possible. The service will also place a close focus upon supporting patients to self-manage their own condition(s).

Area of Quality - Hubs	Impact Questions Could the proposal impact positively or Negatively on any of the following?	Description of Impact (Positive /negative/Unchanged) & Rationale	Risk Rating L C R	Mitigation Strategy & Monitoring Arrangements
DUTY OF QUALITY	○ The duty to secure continuous improvement in the quality of the healthcare commissioned (Health and Social Care Act 2008 Section 139)?	Positive. The introduction of Integrated Care Teams (ICTs) will improve outcomes for people, create access to better, more integrated care outside of hospital, reduce unnecessary hospital admissions and enable effective working of professionals across individual Care Hubs. The ICTs will also be measured against a set of outcomes which are benchmarked against best practice and have been signed off through the Clinical Leaders Group in addition to a set of overarching deliverables to secure continuous improvement which are as follows: • Reduction in the number of case managed patients accessing unscheduled secondary care resulting in a reduction in non-elective admissions; • Increase in the utilisation of pharmacy staff within Integrated Care Hubs to optimise medications for patients under case management • Support for General Practice and the extended primary care team in the management of patients with Diabetes, Heart Failure and Respiratory conditions that makes patient care excellent and delivers individual patient outcomes in line with their management plans aligned with the new models of care	N/A	N/A

		• Support General Practice in the incidence recording of Diabetes, Heart Failure and Respiratory conditions so that the recorded incidence of LTCs is aligned with expected prevalence as suggested by local Public Health and NHSE utilising tools such as the GRASP tool, • Specialist integrated team knowledge and skills to impact positively and be evident in the care plans for patients being case managed, • Patients and the families of patients approaching the end of life are cared for in line with their wishes in their preferred place of care, • Specialist teams contribute to and are active in the delivery of the single care plan, • Identify and implement practices that empower patients so that they identify themselves as feeling confident to manage their long term condition(s) including an increase in number of patients who identify themselves as feeling confident to manage their long term condition, • Increase the use of Technology to support patients to manage their own conditions		
	○ Commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	Positive. The model of care will deliver co-ordinated, quality and integrated care for our frail population and patients with long term conditions in particular, aligned with	N/A	N/A

		primary care. MPFT as a provider are committed to named teams supporting system integration and work is underway to commence implementation of the workforce against population sizes, demographics and risk stratified cohorts to ensure capacity meets demand and care is delivered closer to home. The model will also ensure that patients have the ability to exercise their right to choice as outlined within the NHS Constitution.		
	○ Strategic partnerships and shared risk?	Positive. The ICT will be the delivery vehicle for the new model of care and will form part of a larger infrastructure including locality working, GP Federations, Local Health Economy Clinical Networks and Alliances. There will also be a requirement to work in partnership with wider public sector organisations including district councils, fire and safety, housing associations and the voluntary sector to ensure supportive communities and healthy promoting environments are promoted, developed and optimised. The teams will where appropriate bring in the expertise and enhanced support of teams such as the Home First service to avoid inappropriate admission to secondary care and to support patients to remain independent at home for as long as possible.	N/A	N/A

		It is expected that the service will be delivered through an integrated approach across services and providers, facilitated and driven forwards by Alliance Boards across Staffordshire. It is expected that relevant staff from the following organisations will sit within the scope of ICTs – MPFT;; UHNM; Combined Healthcare; Voluntary Sector; Local Authorities; Primary Care. There is a risk around staffing within primary care and GP recruitment which is picked up in the overarching STP work plan around the GP 5 year forward view and recruitment and retention plan.		
	○ The duty to protect children, young people and adults?	Unchanged. There will be a duty to work with the wider public sector organisations to ensure supportive communities and healthy promoting environments are promoted for good physical and mental health wellbeing across all age life course.	N/A	N/A
	○ Tackling health inequalities and focusing resources where they are needed most?	Positive. The ICT will form an integral part of primary care based clinical services and will work in partnership with GP practices and communities to provide the right nursing and social care services to GP patients in the right way and at the right time. Workforce modelling is being developed taking into account population sizes, deprivation and risk stratified lists to ensure appropriate service provision is wrapped	N/A	N/A

		around populations at a specialist team level supporting an MDT approach to the care of patients with long term condition and frailty and those requiring specialist end of life care. It is also expected that the ICTs will deliver proactive case finding and management for individuals at risk of admission or readmission to hospital, through the use of risk stratification. The purpose of this is to agree with the individual a planned 'shared care' approach which stabilises the individual's condition and prevents further unnecessary admissions and/or supports earlier discharge, The teams will also be arranged in such a way that they can deliver timely, responsive and anticipatory advice to the wider Primary Care Team in support of the safe clinical management of patients in the community based on specialist clinical judgement and patient need.		
EFFECTIVE	○ The implementation of evidence based practice?	Positive. • NICE Guidance – Respiratory; Diabetes; Heart Failure, End of Life Care • BCF 2017 – 19 Policy Framework, Condition 3. • Health and Social Care Integration agenda • GP 5 Year Forward View • Mental Health 5 Year Forward View • NHS 5 Year Forward View	N/A	N/A
	○ Improvements in care pathway(s)?	Positive. The service will be delivered through localities and primary care hubs	N/A	N/A

		moving forwards under a multi-disciplinary approach, utilising risk stratification to identify those patients requiring proactive management and support across a team of specialist nurses, therapists, mental health professionals, pharmacists and social care professionals supported by the overarching governance of specialist consultants where required. The service will be led through strong clinical management within primary care. The ICT will support and integrate with wider community services in the timely and effective management of patients including district nursing, specialist nursing, specialist therapies, community matrons and social care provision. The team will where appropriate bring in the expertise and enhanced support of teams such as the Home First service to avoid inappropriate admission to secondary care and to support patients to remain independent at home for as long as possible. The service will also place a close focus upon supporting patients to self-manage their own condition(s). The ICT will contribute to the delivery of the prevention and self-help agenda for patients under their care, promoting the uptake of services such as the flu vaccine, pneumococcal vaccine, signposting to weight loss, cancer screening programmes and smoking cessation.		
	○ Reduction of unwarranted variations in care?	Positive. The ICTs will deliver the formulation of a single, holistic care plans, owned by primary care, which pulls together	N/A	N/A

		all clinical and social care and voluntary sector contributions and recognises the role the patient/carer has in managing their own care throughout their lifetime. This will recognise multi-morbidity factors to ensure a holistic approach to addressing a patients needs are met. Recognition needs to happen at all points of contact for an older person including physical and mental health, social care and the voluntary sector, and wider place based services. To achieve this there needs to be an emphasis on training the wider workforce and community teams and facilitating them to refer into a specified pathway e.g. frailty. Provide parity of esteem between mental and physical ill health for by reducing rates of depression, anxiety and self-harm in patients and by increasing the rates of access to psychological therapies for patients with comorbid depression and long term conditions.		
	○ Clinical leadership?	The service will be led through strong clinical management within primary care. The role of the Alliance Boards will be key to ensure that services, irrespective of responsible Provider are delivered in a co-ordinated and efficient manner. It is expected that the governance of the model will be driven through the Alliance Boards with organisations working together to develop an accountability model as part	N/A	N/A

		of the service specification.		
	○ Clinical engagement?	Further engagement is required with the Alliances, Community Services clinical team leads on the implementation plan and programme roll out for areas scoped within the programme. A steering group and formal governance structure is in place to drive this forward.	N/A	N/A
	○ Full adoption of Better Care, Better Value metrics?	Positive. The implementation of the ICTs is expected to have a positive impact on the BCBV metrics – managing long term conditions in the community resulting in less demand in secondary care; providing alternatives for urgent care admissions; reduction in the dependency of people on domiciliary care services and care homes.	N/A	N/A
	○ The ability to review quality improvements through core clinical quality indicators supported by good information?	Positive. Enhanced - a number of overarching expected outcomes with measurements are included alongside specific outcomes and measurements for key areas of activity – respiratory; diabetes; heart failure; frailty; end of life. Sample audits of care plans will be undertaken on a quarterly basis. The service will be expected to utilise a set of QALY tools as part of the KPI dataset. Patients and the families of patients approaching the end of life care for in line with their wishes in preferred place of care	N/A	N/A

		will be measured through PCCC outcomes.		
	○ Promotion of self-care?	The ICT will deliver a service that supports self-care and patient education which will equip patients and their carers with the tools they need to understand and manage their own long term conditions. There will also be a focus on the utilisation of appropriate technology such as 'My COPD' to support patients in managing their own conditions.	N/A	N/A
EXPERIENCE	○ Self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)?	Patient satisfaction surveys will be undertaken on patient's views of managing their long term conditions in the community, e.g. diabetes, use of technology to manage conditions. Use of QALYs tools will also inform the analysis of patient experience.		
	○ Patient choice?	Positive. The aim is where possible for teams to be in one place, in one building and one team wrapped around general practice and the locality. Patients will also be free to choose the most appropriate place to receive their care from across Staffordshire and Stoke on Trent.	N/A	N/A
	○ Accessibility of services?	Parity of esteem will be provided between mental health and physical ill health by reducing rates of depression, anxiety, self-harm in patients and by increasing the rates of access to psychological therapies for patients with co-morbid depression and long term conditions.	N/A	N/A

		Travel analysis has been undertaken based upon current provision and proposed options for the location of Hubs which has demonstrated minimal impact.		
	○ Compassionate and personalised care?	ICTs will reach into residential and nursing homes to support patients to remain in their place of residence by wrapping services around the populations, supporting advanced care planning and delivering services to support patients at the end of their life. The ICT will deliver person centred outcomes in a timely manner through the development of personalised care plans across health and social care.	N/A	N/A
SAFE	○ Patient safety and preventable harm?	Unchanged.	N/A	N/A
	○ Reducing healthcare acquired infections?	Unchanged.	N/A	N/A
	○ Clinical workforce capacity (recruitment & retention), capability and competency?	The ICT will consist of a multi-disciplinary team made up of community nursing, Specialist Long Term Conditions Nurses, Specialist Physiotherapists, voluntary sector input, social care, primary care, mental health and pharmacist support with a strong link to prevention and proactive management. The service will support the education and skills development programme of the wider primary care team in reaction to the specialist management of patients with Long Term Conditions and frailty to share learning and best practice.	N/A	N/A

		The service aims to maximise the use of trained pharmacy staff in the management of patients with long term conditions. There are concerns around the retention and recruitment of community nursing		

Commissioning Lead	Name: Gemma Smith	Designation: Head of Commissioning	Date: 18/06/2018
Quality Support	Name: Lee George	Designation: Head of Quality	Date: 18/06/2018
Executive	Name: Zara Jones	Designation: Director of Strategy, Planning & Performance	Date: 18/06/2018

Date Reviewed by QIA Panel:	Tuesday 19th June 2018
Decision:	Approved with conditions: ○ QIA to be updated and reviewed by a further Panel following the completion of formal consultation. ○ Lead Provider & subcontracting contract and quality monitoring arrangements to be further developed and included within updated QIA.