Wandsworth Health and Social Care Community Services
Specification

1.0 Executive Summary

1.1 Background

Health and Social Care Commissioners in Wandsworth are facing a challenging time. Our population is ageing, the prevalence of long term conditions is increasing and the demand for health and social care services is growing – all at a time of difficult financial circumstances. Wandsworth Clinical Commissioning Group (WCCG) and Wandsworth Borough Council (WBC) are jointly addressing these challenges with a comprehensive and innovative redesign of Community Services as part of the Planning all Care Together (PACT) programme; our title for Wandsworth’s evolving Out of Hospital Care strategy for delivering improved care to our adult population.

Improving patient’s experience, supporting self-management and integrating health and social services is the main priority for both the WCCG and WBC and they have worked together to redesign community health and social services to deliver transformation across the entire system to enable excellent care to be delivered in people’s own homes wherever possible thus avoiding expensive and unsettling acute admissions into hospitals, nursing homes and other inpatient facilities whenever safe to do so.

At the October 2012 Wandsworth Clinical Commissioning Board meeting it was agreed to redesign community health and social care services and produce a new specification that would cover all of community services in Wandsworth. An extensive series of workshops took place where the views of service users, carers and patients were sought along with local GPs, social workers, community nurses, community pharmacists and the voluntary sector. Everyone was encouraged to share their experiences, aspirations and to openly challenge ideas about the design of the new specification.

An outline of a specification was designed through the workshops that detailed seven functions needed to deliver community services. A clinical cabinet was then formed to provide clinical scrutiny, overview and insight into the detail of each of the functions and how the functions would interlink and interact as a whole system.

1.2 Aims and Objectives

The overall aim of the Community Service Redesign is to deliver care in the right place at the right time by the right people, doing the right things in the right way.

Our objectives are to:

• Provide a high quality, fully integrated, multi-professional community service meeting people’s urgent, intermediate and ongoing care needs.
• Eradicate the silos, fragmentation, multiple ‘hand offs’ and referral barriers that currently exist in pathways of care.
• Foster a “yes” service culture where community services embrace responsibility for home-based patient care and eligibility is based on patient’s needs - providing them with the tools and services to remain well and independent in their own homes.
• Provide person centred, multidisciplinary, seamless care focussed on pro-active, anticipatory case management of adult service users.
• Enable a reactive service capable of acute interventions whenever necessary.

Community services will be capable of providing care for both acute and chronic needs. Any health, social or voluntary services will be encouraged to access Community Services to support patients and service users to stay safely at home whenever possible.

Figure 1: Patient Pathways: Health and Social Care Community Services
1.3 Summary of Proposed Specification

Wandsworth Clinical Commissioning Group and Wandsworth Adult Social Services staff will be re-organised so that the services they deliver will be grouped in seven key functions. In the current structure staff are generally aligned with disease-specific pathways which has not always served patients with complex care needs and multiple long term conditions well. Structuring community services around functions will enable all staff to broaden their focus; providing holistic health and care needs rather than limiting their activity to only treating specific conditions.

The seven functions required to deliver comprehensive patient care needs are:

1. **Access & Triage**  
To provide initial call handling for any health or social care professional or patient/service user. Includes call handling; information gathering; using information to determine next steps and appropriate onward referral.

2. **Rapid Response**  
Responding within 2 hours to an emerging care need - to prevent an admission into hospital or nursing/residential care wherever safe. The response will include a rapid, multi-disciplinary assessment and intervention focusing on care provision and treatment in the community. Responding to either an urgent health need or a breakdown of care.

3. **Facilitated & Supported Discharge**  
Supporting people to return home as soon as possible following a stay in hospital and arranging the services to facilitate this. Community services will in-reach into hospitals to proactively manage discharges in a timely way and ensure that the necessary services are in place to safely be at home.

4. **Maximising Independence**  
Focussing on maintaining someone in their own home as independently as possible. The care is person centred and goal orientated, focused on rehabilitation/reablement and delivered by a combination of professional groups working together to common aims.

5. **Scheduled Ongoing Care**  
This function provides for those who require ongoing home-based care but whose needs do not require multi-disciplinary case management. The care will be task orientated and will include regular review. Care of this type is currently predominantly provided by the community/district nurses in conjunction with the patient’s regular GP and by individual social services staff.

6. **Complex Case Management**  
People with complex needs will experience care which is planned collaboratively across primary, secondary, community health and social care. Care will be coordinated and seamless and be led by an appropriately qualified case manager. The care currently being provided by the Community Ward and to a certain extent the Intermediate Care Team will be encompassed by this function.
7. Specialist Input
Delivering care where specialist clinical skills are essential – such as that provided by specialist diabetic nurses for example. This function will also ensure links to specialist teams that are outside of this specification such as mental health teams, ensuring a seamless, coordinated pathway between community services and these specialist teams.

Out of Hours
Each of the above functions will have within it the necessary out of hours component to ensure maximum effectiveness.

The above functions will enable a more integrated health and social care platform that has multi-disciplinary, core and non-core staff groups; whose focus is on accepting referrals, holistic and joint assessments, appropriate interventions and the sharing of appropriate information.

Staff will be required to work across functions where there are natural synergies and where it is in the best interest of patient and service users’ outcomes to have continuity of care.

Community health and social services staff will each be aligned to one of four locality teams which will perform all of the functions.

These locality teams will be based in:

- Battersea
- West Wandsworth
- Central Wandsworth
- Balham, Tooting & Furzedown

The whole system pathway for the redesigned community services is represented in Figure 2 below.
Figure 2: Community Services Functions Overview

**Referral**
- Professional and Self Referrals

**Access and Triage**
- NHS 111 and single point of contact
- Adult Social Services Access Team

**Co-ordination and Delivery**
- Four Locality Teams
  - West Wandsworth
  - Central Wandsworth
  - Balham Tooting & Furzedown
  - Battersea

**Community Services Functions**
- Locality Teams will each have all Community Services Functions
  - **Rapid Response**
    - Core: Advanced Nurse Practitioner
    - Social Care Professional
  - **Facilitated and Supported Discharge**
    - Core: Advanced Nurse Practitioner
    - Social Care Professional
    - Physiotherapist
    - Occupational Therapist
  - **Maximising Independence**
    - Core: Independence Champion
    - Occupational Therapist
    - Physiotherapist
    - Domiciliary Carer
  - **Complex Case Management**
    - Core: Community Matron
    - Community Consultant GP
    - Social Care Professional
    - Pharmacist
  - **Scheduled Ongoing Care**
    - Core: Patient GP
    - Social Care Professional
    - Community Nurses
  - **Specialist Input**
    - Nursing
    - End of Life Care
    - Dementia and Mental Health
    - Drugs and Alcohol
    - Learning Disability
1.4 Conclusion

Community services will operate as one service, from both a clinical and a patient viewpoint, with a multidisciplinary platform enabling patients to remain within their own homes for as long as possible and facilitate their return to their own home as soon as possible should they be admitted to hospital.

Patients, service users and their carers should experience no fragmentation, duplication or barriers between the health and social care services they require.

The newly designed Wandsworth Health and Social Care Community Service will provide excellent health and social care in the community and enable people to maintain optimal health and wellbeing whilst providing timely intervention to stem ill health and general decline.

We will achieve this through placing the person at the heart of our services to provide the right support at the right time addressing the full range of their needs and conditions.

Figure 3: Patient Overview of the new system

Maximising Independence
For when I need to regain my independence

Rapid Response
For when I need urgent help

Facilitated and Supported Discharge
For when I've been in hospital and need support to get home safely

Scheduled Ongoing Care
To meet all my ongoing care and support needs

For when I need care and support from an expert in a particular field

Complex Case Management
For when I need care and support that is co-ordinated and planned