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

Service Specification No.	1
Service	Community Matron Service
Commissioner Lead	Cindy Fischer
Provider Lead	
Period	24 months
Date of Review	September 2017

COMMUNITY MATRONS

Aims and Objectives

The Community Matrons will work closely with constituent practices within the assigned quadrant and identify vulnerable patients (working with GPs) and minimise the need for hospital admissions in conjunction with primary care teams and other agencies.

NB: Some of these patients are expected to be on practices' Frail Home Visiting register.

- To deliver high quality community nursing services to the most vulnerable population in City Hackney by working in partnership with all agencies in the borough and participating in the quadrant structure by providing senior input to quadrant meetings and continuity of input into practice MDT's.
- To improve health outcomes for service users by providing a holistic assessment and a package of care that is part of the care plan for that patient and to participate in developing and reviewing the care plan on a regular basis in collaboration with GP's and other services.
- To ensure all interactions with service users are of a high quality and that client feedback is positive
- To ensure high quality communication with patients / GPs / District Nursing Team / Acute Hospital / One Hackney and City initiative.
- To respond to urgent needs within an appropriate time frame and to refer to other services urgently as appropriate

- To provide a service that supports patients to be independent and to remain in their own homes for as long as possible. The service is expected to have an impact on unnecessary hospital admission and length of stay

Service Model

Community Matrons will;

- Manage a case load and proactively coordinate care for patients with Long Term Conditions, while working in conjunction with One Hackney and City initiative.
- Work with constituent practices within the quadrant and District Nursing Team to ensure agreed referral and discharge pathways are followed.
  - Practice based community matrons will ensure attendance at daily cluster hand over meetings at least once a week with district nurses
- Ensure each patient's care plan is in place (or advance care plan, if applicable) and;
  - Is agreed with the GP/ patient / relatives / carers and the patient and their family/carers are actively involved in understanding the care plan and be seen as the patients main point of contact;
  - Communicated to relevant professionals to avoid duplication / and or conflicting treatments;
  - Outlines responsibilities and arrangements in place;
  - Is kept in patient's home;
- Is reviewed at least every 3months in conjunction with the named GP. Ensure a follow up of any significant event and collaborate with the GP and others to review and amend treatment following any acute episodes, hospital admissions and exacerbations.
- Ensure that as far as possible the patients care is provided in the community and work with the GP, primary care team and others to facilitate this.
- Liaise with acute hospitals in the event of an A&E attendance/admission to facilitate a smooth safe and speedy discharge and undertake a review with the GP and primary care team to see whether systems and/or management need to be amended to prevent a recurrence.
- Liaise with One Hackney co-ordinators to ensure provision of appropriate voluntary services.
- Put in place effective handovers and referral processes with Integrated Independence Team, ACRT and other community services.
- Undertake at least 3 monthly home visits with the GP (if appropriate).
- Will ensure attendance at quarterly quadrant meetings and monthly practice meetings

Service Specific – KPIs

KPIs to be reported quarterly in the quadrant structure

Process

- Current caseload register (by practice)
- Number of referrals received (and referral source)
- Number of home visits with GPs / with DNs
- Response time from referral to first contact (Target 24hrs for phone call and 5 days for a visit)
- Proportion of patients with an advance care plan on caseload
- Proportion of caseload on Frail Home Visiting register

Clinical

- Proportion/(Reduction) of over 75 patients/service users with an unplanned attendance/admission
- Proportion / (Reduction) in Over 75 readmission rate
- Proportion/(Increase) of people with care plan and ACP review
- Reduction in falls causing major harm within the home for patients on caseload

Patient

(Minimum 50% target for a positive response is set against each of the following KPIs)

- Proportion of service users who stated that the community matron provided health advice or information about his/her condition.
- Proportion of service users who stated that they were involved as much as they wanted to be in decisions about their care and treatment.
- Proportion of service users who stated that their community matron treated them with respect and dignity.
- Proportion of people who think that the community matron provided information for other available services.
- Proportion of people feeling supported to manage their condition.