FINAL WORKING DRAFT
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SECTION B

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SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	
Service	**Community Nursing Services in North and East Devon**
Clinical Commissioning Lead Executive Commissioner Lead	**Gilly Champion (Eastern), Chris Bowman (Northern) Tamara Powderley (Eastern), Kerry Burton (Northern)**
Provider Lead	**Keri Storey**
Period	
Date of Review	**January 2014**

1. Population Needs

1.1 The Northern Locality covers a total population of 164,500, expected to rise by another 14.5% by 2026

There are 22 GP practices all of whom are member practices of the NHS NEW Devon Clinical Commissioning Group for the Northern Locality and five community hospitals in the Northern Locality all operated by Northern Devon Healthcare Trust

1.2 The Eastern locality covers a total population of 380,000 and is expected to rise by 11.9% by 2026.

There are 53 GP practices all of whom are member practices of the Northern, Eastern and Western Devon Clinical Commissioning Group and 12 community hospitals in the Eastern Locality all run by Northern Devon NHS Healthcare Trust.

2. SCOPE

2.1 Overview

In the absence of a standard specification for services, a community nursing service specification has evolved for patients that meet the criteria of housebound.
This is based around general practice in the Northern and Eastern Locality of NEW Devon Clinical Commissioning Group.

The Community Nursing service is available to any eligible person, aged 18 and over, requiring and accepting of nursing care that is best delivered in their home environment, or normal place of residence, due to the fact that the person is house bound.

The definition of Housebound pertains to :

- Those people with a long term condition that prevents them from leaving their home.
- Those people who are medically compromised in the short term and for a prescribed period are unable to leave their home.
- Those people who for medical reasons are unable to attend the surgery due to their health needs and/or clinical risk to the patient.

This specification describes the current provision, and notes (in no way attempts to standardise) the variation that exists in, but not limited too; referral processes, physical bases, processes of communication between nursing teams and their partners.

The specification identifies issues that require further, detailed work, discussion and resolution in 2013/14 before a final specification of requirements will be defined by the commissioner, no later than January 2014, as part of the national programme and procurement of transforming community services in 2014.

The use of the term “Community Nurse” in this document includes those nurses whose work is based in the community and includes those who have a District Nursing qualification. The use of the term “Community Nurse” is synonymous for both staff groups but does not in any way influence the competencies of the District Nurse qualification.
Additionally, the specification does not include the work of Community Matrons or Rehabilitation Nurses, with the exception of specific reference to the work of the Community Matrons and Rehabilitation Nurses during the time when the prioritisation tool is being applied, see Appendix 3.

2.2 Aims and Objectives

The community nursing service will agree local working arrangements with primary care teams, local complex care teams, rapid response teams, evening and overnight nursing services and community hospital inpatient services to:

1. Provide nursing care in hours to eligible patients, consistent with the housebound criteria as defined in 4.2. (including Devon and non-Devon residents who are temporarily registered with a Devon general practitioner)

These patients will be referred to the service by a member of the practice team, self-referral/carer referral, or referred by another health social care professional (including but not limited to the out of hours GP service, paramedics, or member of another health). The patient will be offered the full range of routine and urgent/same day nursing services including assessment of nursing need, which may include investigations and treatment (including ambulatory care pathways).

The community nursing service will promote the independence of people and reduce the unnecessary use of urgent care and inpatient services (including out of hours doctor services, and A&E attendances).

2. Provide a system of assessment (that includes triage and prioritisation), treatment and care to a consistently high standard that meets all national requirements, and promotes a patient led philosophy and is consistent with:

    2.1.1. Nationally and locally defined guidelines for treatment and care that are consistent with the natural flow of patients

    2.1.2. Demand throughout the year. The service will understand, predict and respond to peaks in demand, and ensure the provision of service is aligned with the different types of demand that present throughout the year and,

    2.1.3. Empowers and support patients and their carers to manage their own conditions effectively, through the provision of education and information.

3. Work collaboratively and effectively with other health and social care professionals and independent providers.

    Use existing structures of core groups, or their equivalent, to proactively identify patients and their carers whose needs are changing and/or are at risk of a 'crisis' or a loss of independence and/or who would benefit from intensive nursing care, including holistic assessment, treatment and rehabilitation.

    The provider will work closely with specialist providers, to develop skills and competencies to meet the needs of patients. For example, the provider will work with local palliative care providers to ensure that the specialist needs of patients, and their carers, who are at the end of their life are met, either at home or their normal place of residence.

4. Contribute to the care of eligible patients on an ambulatory care pathway. These

pathways will be consistent with the natural flow of patients locally and include, but not be limited to, the following: COPD, cellulitis, and collapse.

5. Following discharge from a community or acute hospital, eligible patients referred to the service will receive a holistic assessment and further update of their discharge or onward care plan if required. This will ensure the continuity of care for patients and promote independence at home, or normal place of residence.

6. Contribute to established local safeguarding standard operating policies that are consistent with national guidelines and best practice. The provider will establish mechanisms to promote personal and team reflective practice, to ensure nursing teams can confidently recognise and effectively respond to and manage safeguarding concerns.

7. Establish systems of feedback from professionals, patients and their carers to support regular evaluation of models of care. To ensure that the service maximises the capacity and competency of the workforce, consistent and taking in to account, change in other community or interdependent services.

8. Community nurses will meet regularly in person with the GP and/ or GP practice staff to discuss the patients on their caseload. These discussions will include any risks that are shared across the pathway of care, quality issues and learning form recent SEA's and Siri's (where learning will result in a change of practice).

   The desired outcome of these discussions is the maintenance of interpersonal relationships and connections to enable an effective and high quality experience for the patient.

2.3 Service description/care pathway

The service, consistent with the model of care as defined by the Department of Health will:

• Focus on proactive clinical assessment, treatment and rehabilitation to ensure the prevention of further decline, rehospitalisation and long term care.

• Seek to promote self-care and self-management alongside active health promotion in partnership with primary care practice staff, GPs and public health colleagues.

2.4 Receipt of referral, as the starting point of intervention

Consistent with locally agreed working practices, national guidelines and best practice, on receipt of referral, the registered nurse will triage, and the appropriate referrals, consistent with the definition of housebound, will be allocated a visit by an appropriately trained member of the community nursing team for an assessment.

The community nurse will liaise with, and involve other appropriate health care professionals regarding the patient's plan of care.

Urgent referrals will be made by telephone, the registered nurse will respond to the referrer within one hour and a visit will be allocated within four hours.

For non-urgent referrals, the referral will be triaged and the visit planned according to the clinical need.

The community nursing care plan will include as a minimum, but not limited to, an individual's wishes and preferences, the expected outcome of the intervention, and a date and process for the review of their care plan.

The provider will assume responsibility for all subsequent appropriate interventions on the care plan referring on to other services, which are outside the scope of the community nursing service, as required. This will include signposting or onward referral for carer's services.

2.5 Ongoing review of the patient

The provider will be responsible for establishing mechanisms that:

- Ensure patients, and their care plans, will be reviewed in a timely way commensurate to their need and consistent with the model of care described by the department of health above.

2.6 Discharge from the service

The provider will establish appropriate systems and processes to facilitate the safe discharge of patients from the community nursing service.

Discharge from the service will occur:

- When there is no further clinical need.
- When rehabilitation has been optimised.
- When clinical care should or is more appropriately provided in an alternative setting.
- And, where appropriate, after discussion with the patients registered GP practice and/or other relevant care providers.

The provider will be responsible for establishing local working arrangements to ensure that on discharge there is evidence that:

- Patients, their carers and all other relevant professionals have been involved in decisions regarding their discharge plan.
- An appropriate medicines management plan for the medication prescribed/ or administered by the community nursing service is in place where appropriate and relevant.
- There is evidence of appropriate onward communication if referring to another service.

2.7 Interdependencies with other services

To be effective and deliver all of the objectives described above, the community nursing service will be required to develop effective working relationships and agreed operational protocols with other teams, professionals and organisations working in the community locally to deliver complete packages of care.

These will include, but are not limited to:

- Community hospital services and discharge/onward care teams
- Complex care teams
- Adult social care services (including: rapid response, social care re-ablement and domiciliary care)
- Bladder and bowel services for the supply of continence products
- Dementia support workers
- Older people mental health service
- Primary care (GPs and practice nurse teams) clinical teams
- The primary care out of hours service
- Local providers of equipment and adaptations
- Specialist nursing services including the out of hours nursing service
- The consultant for Older People
- Rapid intervention services
- Reablement teams
- Voluntary organisation

The Community Nursing service receives interpretation services from language line interpretation service and is dependent on this service to be able to deliver services safely

when a patient cannot speak English.

2.8 Hours of Service

The current hours of operation of the community nursing service are described as follows:

- For Eastern Devon the core service will be from 8.30am to 5pm, Monday to Sunday, including bank holidays.
- For Northern Devon the core service operates from 9am to 5pm, Monday to Sunday, including bank holidays.

3.1 Core Service

The core service offered by community nurses is centred upon the delivery of a number of specific care packages to patients meeting the housebound eligibility criteria as stated in 4.2. The individual care plans will reflect the individual's nursing and holistic (Appendix 1) needs.

The scope of work covers assessment and case management for individuals whose needs are predominantly health related, including people who are terminally ill.

This will include care planning, intervention, monitoring and discharge and all of the above, with the implied communications between professionals.

On initial referral to the community nursing service, the registered nurse will start the holistic assessment process which includes; physical, psychological, spiritual and social functioning of the patient’s health status.

The scope and extent of the holistic assessment will be proportionate to the patient’s need/s, risk/s and reason/s for referral, subject to the clinical and professional judgement of the healthcare practitioner.

This will be based on a nursing model of care and include assessment of their activities of daily living. This is the platform for other activities detailed below which form part of the plan of care identified during the assessment process. This will be in collaboration with the patient, their carer, and other members of the multidisciplinary team.

If after assessment, the patient is more appropriate for another service, the community nurse will transfer/signpost onwards. The outcome of assessment will be communicated to the referrer.

As part of the nursing process, the community nursing service will implement and evaluate the plan of nursing care, which has been agreed with the patient/carer. This is expected to be an ongoing activity for those patients who are on the caseload.

The core community nursing service, comprising of registered and unregistered staff, provide the following activities and interventions as part of the plan of nursing care identified during the assessment process:

- **Administration of medicines**. Medications are administered by the community nurse where the route of administration requires clinical skill and competence e.g. injections, flu immunisations and other mandated vaccination programmes for housebound patients allocated on to the caseload.

  This does not preclude the provider making separate financial arrangements with primary care practice or groups. The practice will be responsible for the administration of injections and medications to ambulatory patients. This service will, where appropriate include peripheral line antibiotics, central line drugs and care for patients needing rehydration to facilitate discharge and/ or avoid admission. Where it is appropriate to do so, carers, will be offered a flu vaccination.

  Any person who meets the housebound criteria will be eligible for a flu vaccination or any other mandated vaccination. The physical, psychological, spiritual and social holistic nursing assessment will be the professional responsibility of the nurse, carried out in the spirit of the description of 3.1.

- **Prescriptions and Other Treatments.** There will be occasions when patients will be discharged from an Acute Hospital where the prescription for the administration of medication on discharge will be written up using the Acute Hospital letter headed paper. On discharge, patients return to the medical care of their General Practitioner to continue to manage their clinical care.
  There are already protocols and procedures in place describing the governance arrangements when prescribed drugs and/or treatments are already within the scope, practice and competence of the community nursing team to deliver. These arrangements

include the early review of any prescription and transcription by the GP to the correct paperwork.

However, the expectation within this specification is that any new treatment and/or related requirements must be discussed between the Acute prescriber and the receiving Primary/Community Team, prior to discharge.

- **Chronic disease management.** Community nurses undertake appropriate planned interventions and reviews with patients on their caseload.

  These may include a range of diagnostic tests relevant to the packages of care being case managed. Where reviews on these patient's provide information pertinent to the quality outcome framework in primary care, this data will be made available to primary care. Patient education and the amendment / alteration of treatment in conjunction with an independent prescriber are also provided.

  For clarity, any patient who is housebound but not currently on the active community nurse caseload can be referred and will be accepted by the community nurse service for the diagnostic tests relevant to their condition and chronic disease management.

- **Management of Central lines**, intravenous devices and syringe drivers, this will include ongoing review where appropriate referral to other health care professionals.

- **Wound care, including leg ulceration and tissue viability packages**

- **Continence packages:** Housebound patients with bladder and bowel problems undergo an assessment which is designed to identify the cause(s) of their problem.

  Wherever possible, interventions are used to address the cause e.g. pelvic floor exercises for stress incontinence and bladder retraining for urge incontinence. Irrespective of whether or not the patient is having intervention aimed at cure, they will be assessed for an appropriate form of containment. Promotion of continence and assessment of incontinence, catheter management and acute and routine bowel management.

- **Diagnostics:** A range of diagnostic tests relevant to the packages of care being case managed by Community Nurses will be carried out from venepuncture, Doppler studies, blood glucose, blood pressure and urinalysis. Standard Doppler test of arterial

functioning are not performed unless they form part of a more comprehensive assessment of a patient's tissue viability problem.

- **Therapeutics:** Community nursing specialist practitioners hold a nurse prescribing qualification and are able to prescribe from the Nurse Prescribers Formulary for a range of health needs.

  A number of practitioners have qualifications as independent supplementary prescribers and these individuals will prescribe a range of medicines (within their scope of practice). Where the practitioner is delivering care in accordance with this service specification, there will be a need for communication with other practitioners involved in their care. Notably communicating prescribing decisions to the patient's general practice as soon as practical and no longer than 48 hours (excluding bank holidays).

- **Aural care:** Patients experiencing problems with ear wax are assessed by a member of the community nursing team who has been trained in aural care. Where possible alternative methods to syringing, including the removal of softened wax using forceps are utilised. Ear syringing may be used as a last resort. Aural care also includes advice to patients on the prevention of subsequent problems.

- **Palliative care:** Community nursing staffs are involved in delivering a range of palliative care to patients with cancer and other terminal illnesses. Care of this nature is often very intensive and includes all aspects of physical care for patients and psychological support for patients and their families. In addition, community nurses working collaboratively with GPs, Macmillan and Marie Curie Nurses are involved in symptom control; including assessment, recommending medication review and the administration of medicines.

- **Post surgery:** Facilitation of rehabilitation following surgery, disability accident or illness. Referrals from acute care for all patients with surgical complications post-surgery. This may be achieved in collaboration with the multi-disciplinary team

3.2 Workforce

Community nursing services will be comprised of registered and unregistered nurses and be configured on a geographic basis around clusters of natural communities, GP practices and wherever possible be co-terminus with social care teams.

Bases/facilities should be safe, accessible, equipped with functional IT systems and within a location that supports a timely response to referrals. To enhance the ability to work

collaboratively with other service providers as well as reduce the need to travel (Ref. Green Travel Plan) e.g. general practice, mental health teams and social care. The environment in which staff works i.e. patients homes will be risk assessed at first contact.

4. REFERRAL, ACCESS AND ACCEPTANCE CRITERIA

4.1 Referral

There is currently no standardised, formal system of referral to the service. Local referral processes between primary care, hospitals, other professionals and community nursing teams have evolved over time.

There is significant variation in the current referral processes. To maximise clinical time and ensure the appropriate and safe prioritisation of work the provider and commissioner will work together to determine how referral process will be improved during 2013/14.

The scope of this work, actions and timescale governing this work is overseen by the 'Routine community nursing referral pathway' project. The outcomes of this work will

- maximise the clinical hours of the nursing service to the delivery of care
- ensure a simple referral pathway for routine referrals for all referrers
- Ensure minimum standard of referral information is received to enable safe triage of incoming referrals

Consistent with the aims and objective of the service, the nursing service will accept referrals from, but not be limited to:

- The patient or their carer
- A member of the primary care team
- The contracted urgent care primary care service
- 111 service
- Complex care teams
- Social care professionals
- Community and acute hospitals
- Registered residential homes
- The ambulance service – including crews and paramedics on scene
- Private and voluntary sector, including care agencies

4.2 Acceptance criteria

As previously stated, the community nursing service is available to any eligible person, aged 18 and over, requiring and accepting of nursing care that is best delivered in their home environment, or normal place of residence, due to the fact that the person is house bound.

The definition of housebound pertains to :

- Those people with a long term condition that prevents them from leaving their home.
- Those people who are medically compromised in the short term and for a prescribed period are unable to leave their home.
- Those people who for medical reasons are unable to attend the surgery due to their health needs and/or clinical risk to the patient.

The community nursing service will provide nursing care in the patients' home environment or normal place of residence when they are unable to attend their surgery due to health needs and/or clinical risk to the patient, consistent with the above definition, noting the exceptions below:

- Any person aged under 18 years in transition from children's to adult services or for those children referred to the service the provider's decision to accept the referral will be made in collaboration with any current children/youth team care manager and/or be based on a clinical judgement and clinical competence, having risk assessed the implications and providing feedback to the integrated children's services.

  However, consistent with national and local policy the provider will:

- Be expected to agree working arrangements/standard operating procedures to ensure the appropriate care and/or onward referral of patients who are identified by referrers or the service, as being violent.

- Consistent with national registration requirements, not normally, and only by exception, the provider may deliver interventions to patients who are resident in nursing homes. Each intervention offered, in the best interests of patients, will be logged by the provider with the CQC as a safeguarding alert.

In addition, the provider will identify those patients registered with GP practices in Devon but residing in geographical areas that are significantly remote to the practice, and therefore impact operationally on the provision of community nursing services.

The provider will establish local working arrangements with practices to ensure that GPs are aware of the remoteness of the patient and the clinical time taken to provide nursing services to this group of patients. A local decision between the nursing service and GP will determine if continuation of this care or referral on to another community nursing team is appropriate.

4.3 Referral response

The provider will establish local working arrangements with primary care teams to agree how referrals will be prioritised, consistent with the overarching principles of the service to promote independence and reduce the use of unplanned care services.

The provider will establish working practices to ensure all patients prioritised as requiring an urgent intervention are contacted by telephone where possible within 1 hour of triage by the registered nurse within 4 hours of the referral.

Where possible, the provider will establish working practices to ensure all patients prioritised as requiring a non-urgent intervention, are contacted by telephone on the day of triage by the registered nurse. These patients will subsequently be prioritised, consistent with local working arrangements and according to need.

There is a joint responsibility of both commissioner and provider to maximise the clinical time available to be spent with patients. To ensure the appropriate and safe prioritisation of work, the provider and commissioner will work in the first quarter of the year to determine how local prioritisation processes could be improved.
The scope of this work, actions and timescales governing this work is defined in the Prioritisation Tool, appendix 3.

4.4 The management of inappropriate referrals

Urgent referrals that are inappropriate will be managed via the telephone discussion with the referrer.
For non urgent interventions, the inappropriate referral will be returned via an email to the

referrer within one hour of triage with a rationale for the referrals return.

The Cascade for the resolution of disputes is identified in Appendix 2.

5 APPLICABLE SERVICE STANDARDS

5.1 Applicable standards

The in hours community nursing service provider must be registered for the provision of health services, and must comply with the standards outlined in this specification for patients who met the definition of housebound. Compliance with the outcomes, standards, inputs and outputs described below must be demonstrated through an agreed performance management framework.(Ref.4 NHSC)

The service will apply evidence-based practice and will be informed by National and Local drivers for change for example:

- Current DH policy and guidelines, delivery of national key targets &NSF & NICE guidelines
- CQC registration requirements
- Gold Standards Framework and Liverpool Care Pathway for people at the end of life
- Essence of Care
- The Hygiene Code
- Locality commissioning plans and locally agreed Care Pathways
- Devon Joint Health & Wellbeing Strategy 2013 – 2016
- Care in local communities: a new vision and model for community nursing (DH, 2013)

5.2 Local Quality and Key Performance Indicators

(Ref.32. NHSC): The provider will be expected to meet the registration requirements of the Care Quality Commission in addition to the locally agreed quality and performance indicators. A breach of any indicator contained within the local quality and activity schedules as set out in Sections 6 and 13 of the specification will result in performance management action as detailed in Section 32 of the NHS Contract for Community Services.

5.3 Provision of Information

(Ref.29. NHSC): The failure to provide information in a timely manner and as set out in the quality and activity schedules in section 6 and 13 of the specification, and/or in accordance with the Data Quality Improvement Plan for the relevant contract year will be viewed as a breach of the relevant indicator, core standard or any other breach as set out in the above, and therefore will be subject to the same processes and escalation as set out above.

6 QUALITY AND PERFORMANCE

6.1 General

The service will comply with NEW Devon CCG policies, procedures and guidelines on patient safety, service delivery standards and quality, equity and diversity.

Community Nursing Services will be required to undertake systematic reviews and analysis of the quality of care provided. This will be through a range of methods including; patient feedback, patient involvement in service improvement, review of clinical records, clinical audit and governance arrangements.

The performance framework for the provider of community nursing services is set out as follows:

- The provider of community services will meet with the commissioner and/or the appointed contracts manager on an agreed basis through a formal contracts meeting process to discuss service performance. Amongst other considerations, these meetings will ensure that performance is linked to the delivery of the service in local areas.
- The commissioner will issue minutes following each performance meeting, setting out its areas of concern, noting areas of success and confirming agreed actions.
- The commissioners will reserve the right to serve a performance notice or remove services from the list currently provided. The notice period will be:
    - With immediate effect if the performance concern is repeated failure or catastrophic
    - Three months' notice if the performance concern is major
    - Three to six months' notice if it involves over the contract condition amount.

Note: The commissioner may choose not to use these actions if it is satisfied that in its own opinion, all reasonable steps are being taken to address the identified concern.

6.2 Measurable Quality Markers

The Quality Markers (Section *ref to be inserted*) and Key Performance Indicators (Section *ref to be inserted*) will form part of the Provider Annual Report. These Quality Markers are in the main national 'Vital Sign' performance measures and form part of the NHS contract requirements (Ref.29. NHSC).

7 QUALITY MARKERS

Note: KPIs are to be completed by March 2014 following feedback from Eastern and Northern localities initially and subsequently informed through the developmental document and associated work.

8 KEY PERFORMANCE INDICATORS

Quality and performance indicators	***Quality and performance indicators***	***Threshold***	***Method of Measurement***	***Consequence of breach***
Service User Experience			Patient Survey	
Improving Service User and carer experience			To be defined	
Contact activity			ComPAS data	
Personalised Care Planning	Improving and sharing individualised care plans		Development of a single personalised care plan to be shared and recognised by all agencies whom the patient comes into contact with	
Staff turnover rates			ESR	
Sickness levels				

			Service retention, sickness and absence will be monitored by the provider and fed into data relevant for the NHS function. The provider will maintain continuity of care.	
Patient safety	Evidence of significant event reviews (SIRI, SUI) Hand Hygiene audits Infection control Documentation audit		Clinical effectiveness dashboard	
GP user satisfaction	- Access - Satisfaction - Communication		Survey monkey style questionnaire at the beginning of the year and at month 10	
Community nursing dashboard: **1. Face to face contacts with patients pr proxies in total**			ComPAS Data	
2. Mean visit length for these contacts			ComPAS Data	
3. Number of these contacts lasting 60 minutes or longer			ComPAS Data	
Care Pathways			To be defined	

Reporting	*Encouragement of staff to ensure reporting*		To be defined	

Appendix

Appendix 1: Glossary

Holistic assessment:

Nurses will be expected to use their professional judgement in allocating their time most effectively in assessing and attending to the needs of the patient, which may reflect physical, social, psychological and spiritual needs.

Housebound:

The community nursing service is available to any eligible person, aged 18 and over, requiring and accepting of nursing care that is best delivered in their home environment, or normal place of residence, due to the fact that the person is house bound.

The definition of housebound pertains to :

- *Those people with a long term condition that prevents them from leaving their home.*
- *Those people who are medically compromised in the short term and for a prescribed period are unable to leave their home.*

Those people who for medical reasons are unable to attend the surgery due to their health needs and/or clinical risk to the patient

Caseload:

The term "caseload" describes those patients who are in receipt of active nursing care from the community nursing team. This cohort of patients will be a subset of Housebound patients; all of whom are eligible to be accepted on to the community nursing caseload as and when they have a nursing need.

Appendix 2: Escalation Process

Cascade for the resolution of disputes

This section details the process to be followed where there is a difference in perspective between the referrer and the community nursing team regarding the appropriateness of the referral. In the majority of cases the referrer will be a General Practitioner or Practice Nurse within primary care.

The principal behind this process is patient safety should not compromised.

Start of the process

There is a difference of view between the triaging community nurse and referrer re the referral.

1. The community nurse to notify the referrer and the generic Practice email why the referral is not a suitable referral. This will be in writing via email with a follow up call if required.

If the issue remains unresolved;

2. The community nurse will escalate to the Team Manager to review the situation. The team manager will call the surgeries Practice Manager or the referrers line manager for discussion and detail this in a follow up email.

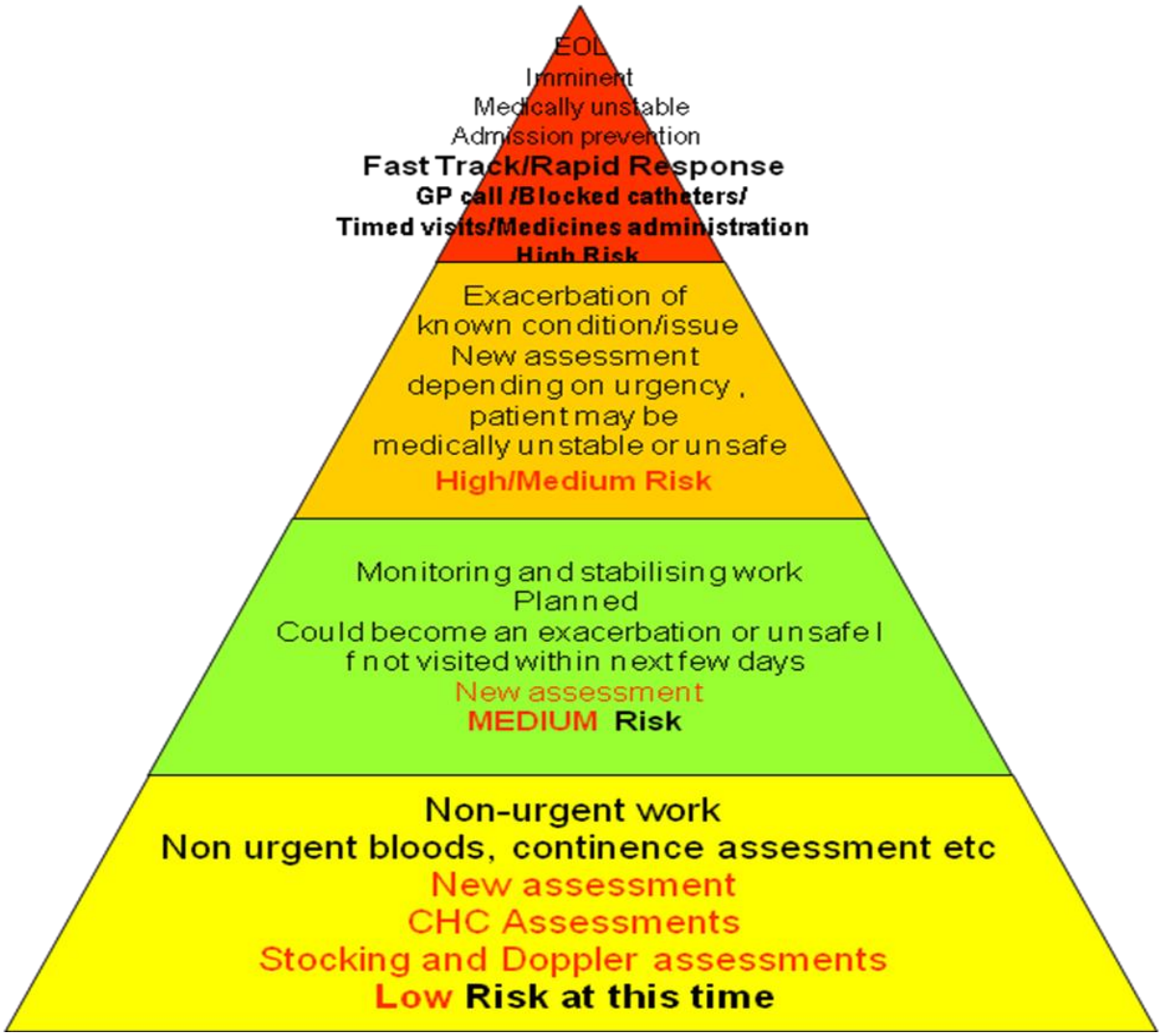
If the issue remains unresolved;

3. The team manager will escalate to the cluster manager who will review the correspondence and the situation. The cluster manager will seek further resolution before cascading this to the deputy assistant director who will liaise with the responsible CCG commissioner.

Appendix 3: Prioritisation Tool

This pyramid describes prioritisation for all Community Nursing services to include Community Matrons and Rehabilitation Nurses. The process of prioritisation within specific areas will utilise all community nursing services according to capacity and demand.

Decision making pyramid uses professional judgment and experience. Based on principles of stability/ instability/ predictability/ unpredictability RCN 2001



Red –visit within hours
Amber within the day
Green within days
Yellow- can be reprioritised
From caseload