PREVENTION & EARLY INTERVENTION SERVICES

Lot 4 (Draft Specification)

Home from Hospital, Supporting Recovery & Maintaining Independence (Outcome 4)

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1 Introduction

The changing pattern of care needs requires greater integration – that is, much better alignment – in the commissioning of health and social care services. In view of this the London Borough of Enfield, along with Integrated Commissioning Board ICB (Enfield Borough) aim to commission prevention and early intervention services, as well as discharge support to meet the care and support needs of the communities within the Borough of Enfield. These services will require collaborative and joint working from the voluntary and community sector to meet the requirements of the commissioning process.

As part of this process, the Council and the Integrated Care Board, Enfield, (ICB) wish to work with Service Providers who are able to demonstrate an ability to support the care needs of people to focus on outcomes, using a person-centred approach. Service Providers are encouraged to work together as partners within a consortium structure and delivers support flexibly meeting individual needs. This will be our key driver in procuring services for vulnerable people in Enfield.

This Specification is split into two distinct Parts:

Part A: Home from Hospital and Supporting Recovery

This part of the specification supports people to leave hospital and those with short-term needs in the community. Support will extend to helping and people with everyday tasks, like shopping, walking, making phone calls, providing information, and linking in with Part B of the specification to ensure the people maintain their health and well-being avoiding re-admission into hospital. The service will be available for up to six weeks. The overall aim is to

1. To give people the best chance of making a good recovery
2. To improve health and wellbeing
3. To improve quality of life
4. To reduce loneliness and isolation

The above service will be available to all Enfield residents aged 18 and above.
It is important to ensure that the services delivered are accessible to all eligible Enfield residents, reflecting their diversity and range of needs and aspirations.

Part B: Maintaining Independence

This part of the specification is based on a new outcome-focused care and support model throughout the Contract term to meet the Council's strategic objective that vulnerable residents are safe and supported with choices to live healthy and informed independent lives and support is provided to enhance resident's social integration within the community they live in. Aligns to this is the ICB core values of 'Start Well, Live Well, Age Well'.

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This specification sets out the minimum standards and requirements that the Council and ICB will expect from the successful Service Provider who are delivering acute discharge support and preventatives and interventions services to vulnerable people residing in the borough of Enfield.

2 Aims and Objectives

The overarching aim is to support people to regain their health and confidence, participate in their local and wider communities; enhance effective personal support networks; enable individuals to maintain healthy lifestyles; and lead independent, healthy, and fulfilled lives.

A collective commitment of the health and care system in Enfield is to fundamentally transform how and where we will support people to keep well and live well. We will help people to understand that hospitals and residential care settings aren't always the best place to receive care. Clinical evidence shows us that many people, particularly frail older people, are often better cared for closer to home surrounded by the people they know and with the rights tools and community asset to support them to stay well.

Many people are fit to return home but need some assistance with transport, personal care and/or other support in the early days of discharge to regain their confidence and strength. Our objective is to offer hospital and clinical discharge support and after care visiting and support services especially for people who live alone. At the end of the short-term help, people should be able to remain at home safely without any further need of support.

Where people need further assistance to better integrate into their community due to the lack of ongoing support network and social isolation the Service Provider will work with the borough's vibrant social, voluntary and community sector to support people to look after their health and wellbeing, connect with others, manage any long-term conditions, and stay independent. Support in this area will include information, advice, guidance, signposting, and referrals into relevant services and monitoring the take up of new services of people being supported.

In addition to providing tailored and individual support the Service Provider will enable individual to access community-based activities and interventions delivered by a range of appropriate and skilled voluntary and community Service Providers. Access to service may also include direct provision.

The overarching objective is to: -

- Assist and enable smoother, safer discharge processes by supporting individuals and their carers to be involved in discharge care planning.
- Take a person-centred approach, facilitate people and their carers to navigate the care system and make choices both now and in the future about the help, care, and support available to them from diagnosis onwards and to be a point of contact for these individuals, including providing advice, information, and signposting to advocacy services. This takes account of supporting people to confidently access and use digital applications to respond to their needs.
- To help users of the service to feel more confident and safer in their home.

- To ensure people have an increased and improved individual positive experience of services in the community and in hospital.
- Reduce length of stay in hospital through facilitated early discharge by supporting users to self-care at home.
- Reduce emergency admission and readmission to hospital.
- Reduce delayed discharges for people not otherwise eligible for social care support.
- Ensure carers are adequately informed, consulted and prepared to care.
- Help people care for themselves at home for as long as possible.
- Provide information advice and direct services for people and their carers to stay well e.g., healthy eating including the provision of hot meals through luncheon club services, well-being and peer support services, social interaction, and improved lifestyle.
- To raise awareness and understanding of diseases that impact more on old people e.g., stroke, heart disease and dementia to enable people to live well with the condition.
- Provide time limited education and support to people and carers including support in self-care to improving adherence, risk factor modification, symptom control, functional capacity, and overall well-being.
- Information and support for patients and families considering supported living or residential care.
- Monitor and evidence measurable improvements in terms of achieving healthy lifestyles for peoples and their carers.
- Ensure that people and their families/ carers receive an excellent experience through all aspects of the care pathway.
- To ensure peoples and their carers are active citizens and can influence and contribute to the design of services and services are flexible and responsive enough to work within the changing landscape.
- To work collaboratively with partners taking on board co-production in service design and operation
- To help identify and work with any circle of support (family, friends etc) who can contribute to the overall well-being of an individual

This Partnership working will help reduce the demand for statutory services and build up awareness of existing alternative community-based solutions and individual support networks.

3 Strategic and Local Context

Locally, the importance of supporting people to achieve their full potential is headlined within Enfield's Council Plan. This specification builds on the Council's Plan aiming to ensure people in Enfield live healthy and well by way working towards achieving the below strategic goal.

Strong healthy and safer communities

- *Protect vulnerable adults from harm and deliver robust early help and social care services.*
- *Work with our partners to provide high quality and accessible health services.*

Enfield's population are living longer but this does not always come with good health. The number of people with complex needs is increasing and the number of older people managing long term health conditions, that limit the quality of life is also on the rise.In terms of support arrangements, in 2023 the landscape demonstrated the following *:*

People Aged 18-64

- Estimates from 2020 indicate that, among working-age people (aged 16-64 years), 53,000 had some level of disability – around 25% of the working-age population.
- The number of emergency hospital admissions in Enfield was 1,748 per 100,000 in 2022/2023. This was higher than the London average.
- 768 people in 2022/2023 admitted to hospital was diagnosed with a nutritional deficiency.
- Between September 2022 and October 2023 195,000 Enfield residents presented themselves to A&E at North Middlesex hospital
- 18,919 people under the age of 65 live alone and 8.1% of our residents in Enfield aged over 18 feel lonely 'often' or 'always' compared to 6.5% of London and England residents.

People Aged 65+

- Over 6,363 older people provided unpaid care (rising to nearly 7,554 by 2030)
- Nearly 13,990 older people unable to manage at least one domestic task (rising to over 16,335 in 2030)
- Over 13,830 older people unable to manage at least oneself care activity (rising to over 16,218 in 2030)
- Dementia is also on the rise and prevalence amongst the population aged 65 at 63.3%.
- The highest risk of falls is in those aged 65 and above. Up to 20% of this population who contact a medical service for assistance are classified as serious falls leading to hospitalisation and ultimately residential care.

Public health evidence shows that the prevalence of disease is higher in more deprived areas in the borough. People in the least affluent socio-economic areas have a 60% higher prevalence of chronic diseases than those in the highest socio-economic areas. Reducing the prevalence of these long-term condition and disease amongst the local population will play a crucial role in reducing mortality, emergency use of health care and needs for health and social care.

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Demand for short term step-down placements supporting people to leave hospital before returning home has increased and this type of service will be in demand as the strategy to support people within their own homes continues to be embedded.

There is evidence of the association of falls, due to low levels of physical activity, and being socially isolated and/or lonely. Reviews of the evidence indicate that participation in higher levels of physical activity can be protective against repeat falls and perceived social isolation in community dwelling for people.

The priority for many people who seek help in their care is to remain living at home for as long as possible, with wrap around care and support services they require it. To this end, we will continue to support individual choice to remain living at home where possible through the provision of services which meets care needs supported by the use of equipment, assistive technology, comprehensive and inclusive information and advice and the utilisation of the borough's VCS community assets.

4 Outcomes

4.1 Outcome rationale

The basis of this specification is informed by a number of key drivers, which include the Council Plan, which sets out our commitment to create strong, safe, and healthy communities the Health & Wellbeing Strategy, Integrated Care Partnership Plan, and the Care Act 2014 (Information 'key delay and prevention of dependence'); and continuous improvement in terms of providing quality services to the citizens of Enfield.

The need to work together to support independence health and wellbeing is central to our joint strategic documents,

4.2 Expected Overall Outcomes:

- Through a strength base approach more people feel able to maintain a good standard of wellbeing.
- People have a choice of appropriate activities which promote wellbeing.
- People are able to live independently and safely in the location of their choosing for longer. This will require the Service Provider to inspect the homes of people.
- Improved Partnership working effectively within a Multidisciplinary and Co-production environment, working alongside GP's and other health professional to include uptake of referral from these area.
- People are better informed and can access information using a variety of communication channels.
- People feel settled and secure in their accommodation choices.
- Contact with in-patients at an earlier stage to discuss needs (e.g., housing/tenancy sustainment, sustaining employment) – planning is timely.
- People feel consulted, involved, and supported through the discharge process.
- Increased awareness of services available to support recovery.

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- Reduced hospital readmission and presentation within A&E
- Reduced recovery times
- Carers feel confident to continue to care.
- More people in contact with support service before and after discharge
- Reduced number of complaints
- Opportunity to expand volunteers within the community.

4.3 Key Outcomes for Part A and Part B

Part A

Home from Hospital and Supporting Recovery	The key outcome is that people are confident and enabled to live independently at home rather than in a hospital setting by ensuring that the quality of support in the home is right. Should the need to be admitted to hospital arise then the people should have a clear understanding of how their care and support will be managed during their stay. Peoples who are medically stable and have reached. an appropriated level of physical and cognitive recovery will be discharged as soon as possible. The discharge process will be more efficient and effective taking into consideration. the person's continued rehabilitation/enablement in their home environment and the support needs of their carer to continue their caring role and maintain their well-being.

Part B

Maintaining Independence	The key outcome is to provide suitable interventions so that peoples and their carers can continue to live independently within their own homes, avoid crisis or presenting themselves to A&E and/or hospital admission. Service pathways will be co-ordinated and streamlined so that those using the service have a better experience and are confident that they have the appropriate advice and information and services to keep them well. The Service Provider must support people to achieve their personal aspirations; participate in their local and wider communities; enhance effective personal support networks; enable individuals to maintain healthy lifestyles; and lead independent and fulfilled lives. Support will be personalised to the individual and is high quality and responsive so that users of the service are confident to self-care and carers feel they are equipped,

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	healthy and able to undertake their caring role. This area of support will require direct or indirect service provision

Emphasis is placed on the heightened need to coordinate the activities between Part A and Part B of this specification and to provide support across health, social care, and the voluntary communities for vulnerable people and those with physical or mental health needs. It is therefore essential that the outcome-based approach to supporting vulnerable people is person-centred, holistic, and integrated across health, social care, and the Service Providers

4.4 Key Outcomes Integrated Care Boards (ICB)

Supporting a Home First Approach: improving the transition and experience from hospital to home and reducing length the of stay.	A key outcome will be to deliver a high - quality service, using a patient first approach to improve the quality of discharge and transfer to a person's home: • Ensuring that people are able, to live independently and safely in the location of their choosing for longer. This will require the Service Provider to inspect the homes of people. • Strengthening Partnership working, fostering a Multidisciplinary and integrated approach, working alongside primary care, acute and community-based health, and social care teams. Demonstrating active engagement with anticipatory care MDT models. • Promoting earlier engagement with in-patients to discuss needs (e.g., housing/tenancy sustainment, sustaining employment), to support early intervention and mitigate potential delays. • Ensuring that people are well informed and can access information using a variety of communication channels.
Preventing readmission and maintaining independence	• Improving the choice of appropriate activities which promote wellbeing- and awareness of services available to support recovery. • Signposting to appropriate statutory and VCSE services, including mental health, Local Area Coordinators, anticipatory care teams. • Delivery of a full wrap around connected service people before and after discharge.

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Equity of access to services across NCL to support population health objectives.	A key outcome is to deliver a person-centred service that is consistent across North Central London. This has three elements: • That all Enfield residents have access to the service from any hospital or community inpatient unit within NCL. • That a set of minimum expectations is agreed across the 5 boroughs with regards to services offered to ensure consistency for residents. • That ethnic background, age and gender are monitored to enable better identification of populations that may not be accessing the services successfully with a view of being able to improve this.

The pandemic has accelerated the use of technology for many people. It's also highlighted, exclusion as some struggle to use new systems. The Service Provider will embrace the use of technology and the need to equip people with the means to maximise benefit from this, understanding that this might mean different technology and digitalised solutions to meet different care and support needs.

The Voluntary and Community Sector plays a vital role in helping people have the information they need to live independently whilst working alongside Adult Social Care to support the Council's Prevention and Early Intervention Agenda.

6 Definition

6.1 Definition

Part A is defined as

Having a multi-agency, integrated discharge approach, and bringing dedicated health and social care professionals and members of the voluntary sector together to ensure people can be discharged from hospitals on the correct pathway in a safe and timely way and can continue to live safely within their home.

Part A Home from Hospital and Supporting Recovery

Primary Prevention	Definition
	To support peoples who are at risk of hospital admission or re-admission and enable those in hospital who are medically stable and

	have reached an appropriate level of physical and cognitive recovery to be discharged safely back into their community. To provide support to peoples at home allowing them to reach their full potential to live safely and independently in their community by ensuring appropriated intervention and support is provided by the voluntary and community sector in a personalised way and reduces the demand for health and social care support. Following discharge support the people home will be check for safety, appropriate heating and ventilation and food stock. Shopping and light household duties will be included within the primary task. Information and advice will be provided as well as form filling, benefit advice and making telephone calls. Support will be provided for up to six weeks.
Secondary Prevention	This area is focused at ensuring peoples discharged from hospital continue to remain safe maintain their independence through integration with their local community. This will be facilitated through the task and pathways related to Part B of the specification with clear outcomes for the peoples monitored and captured through performance management.

Definition

Part B is defined as -

Finding innovative ways in helping people to remain independent and have fulfilled lives, enabling them to be in control and play the part they have always had in their local community. Building on individual strengths and emotional wellbeing and ensuring networks are created to prevent social isolation.

Part B Maintaining Independence

Primary Prevention	Definition
	Service provision focused on low level support helping people. who need support to keep them living independently within their own home. In particular, the low-level support service would focus on primary prevention i.e., maintaining independence, educating and promoting good health and wellbeing and some secondary prevention i.e., identifying individual at risk or living. with specific health conditions i.e., heart disease or events such as stroke, dementia or falls – Services will help maintain independence, health, and wellbeing. by improving access to universal good quality information about local services, Promoting health and active lifestyles. Practical support will be. delivered that helps people with small tasks, whilst promoting

	social contact for people and a positive image. Services will facilitate access to local services that are important. to vulnerable people and their carer e.g., transport, leisure, health services, housing services, libraries, information and advice Services that support people to maintain a sense of health and wellbeing.
Secondary Prevention	Services will act as an 'early warning' system by putting. mechanisms in place to ensure that those 'at risk' of suffering health related problems, are identified and supported to self-manage their conditions and have the ability to liv independently in their community. Services will refer to the appropriate agency should risk to a people's well-being increase or as and when required. Services will help identify and work with any network and/or circle of support an individual may have who can contribute to their overall well-being. .

7 Service Description

7.1 Part A Home from Hospital and Supporting Recovery

Avoiding Hospital Admittance

This will be a whole-system partnership model of integrated care. It ranges from supporting people who are medically optimised for discharged from the acute hospitals of including the Royal Free London NHS Foundation Trust, North Middlesex University Hospital NHS Trust, Chase Farm hospital, Magnolia Ward and Barnet, Enfield and Haringey Mental Health NHS Trust to have an early or timely discharge back into their Homes. Support to the individual will be provided to ensure they settle safely within their homes and have access information and advice and community support.

Services delivered should provide an opportunity for significant improvement to people's ability to care for themselves and improved pathways through a focus on: -

1) The provision of information and advice for those who are able to manage their own needs taking on board digital solution to responding to need.
2) Prevention and early intervention services for people at risk of deteriorating health
3) Working in partnership with Adult Social Care, Mental Health Services, Community health services, GPs and in the acute hospitals to ensure coordinated, effective planning of discharge to a person's own home.

4) Providing support for people in need of rehabilitation, and those at risk of admission to a care home
5) Providing support for people who are ill and at risk of admission and re-admission to hospital.
6) Provide support at home for End-of-Life users wanting to stay in familiar surroundings.

For this to be successful the following will be required: -

- A point of Access – to include GP referrals, Hospital base, Multi-Disciplinary Meetings through the Integrated Model of Care
- Working with key health and social care partners in the identification of those peoples at risk and assessment process as an outcome from the multi-disciplinary meetings
- Sharing Information Protocol

The Service Provider will work within GP based practices and Acute Sites where referrals will be made for peoples who live on their own and who are deemed 'at risk.' The referral will guide the appropriate intervention that will need to be provided to people who use the service in their own home/place of residence i.e., support with medication, nutrition, identifying trip hazards for those experiencing repeated falls. The Service Provider will ensure high quality co-ordinated support so the people at risk can live safely in their home through the self-management of their care.

Risk stratification tools, clinical experience, and data on people episodes of care will be used to identify the actions to be taken. Criteria includes:

- Type of Hospital admissions
- Frequent A&E attendances
- Long Term Conditions
- Level of multi-agency input

The Service Providers will also work with Enfield Adult Social Care, ICB, BEH Mental Health Trust, to develop a safe discharge pathway to ensure safer discharge planning with peoples and their carer. The Service Provider will support peoples identified as ready for discharge through the 'Discharge to Assess' initiative and will work alongside care professionals at ward level to ascertain what the patient would need to support a safe discharge back into their home together with any carer's support needs.

Once discharged the Service Provider will assist with the assessment at the people's home along-side key professionals and provide the appropriate intervention i.e., falls prevention, stroke, diabetes, or dementia specialist services.

The Service Provider will ensure that the people are safe, confident, and comfortable in their home following discharge and provide a range of re-settlement services to include: -

- Preparing home prior to discharge i.e., checking home is presentable, putting heating on or airing.
- Supporting people with issues around their tenancies or employment

- A time limited health and well-being check
- Collection of medication from the pharmacy
- Basic shopping requirements
- Checking prescribed medication is being taken.
- Ensuring equipment or assistive technology has been delivered and is being used correctly.
- Effective self-management of personal care and mobility in the home
- Effective self-management of nutrition and cooking ability where appropriate
- Checking domiciliary care arrangements are in place and active.
- Identifying and managing risks which may impact on the people's ability to stay safe in their home i.e., housing condition, identifying, and managing trip hazards, housing maintenance and support to pay bills or claim benefits.
- Act on any presenting changes to symptoms not normally associated with the people and refer or liaise with specialist services.
- Direct assistance with, or regular encouragement to perform, tasks of daily living i.e., bathing, dressing, cooking and domestic cleaning.
- Advise and support skin care such as moisturising very dry skin.
- Providing advice and support on self-care skills including signposting to sites such as Community Hubs Dementia Care and Carers Support
- Signpost to and help arrange social/leisure activity to alleviate depression and isolation.
- Assistance with putting on appliances with appropriate training for example leg calliper, artificial limbs and surgical stockings and assistance with visual and hearing aids e.g., glasses care, hearing aid battery checks.
- Support to attend day services and any GP, memory clinic or hospital appointments.

7.2 Part B Maintaining Independence

Health and Wellbeing and Community Participation

The overall aim is to support people to achieve their personal aspirations; participate in their local and wider communities; enhance effective personal support networks; enable individuals to maintain healthy lifestyles; and lead independent and fulfilled lives.

The required service within this area is broken down into 3 distinct areas as follows.

Information & Advice	The Service Provider will provide good quality information and assist with completing initial forms where appropriate. Support individual to access and utilising digitalised and assistive technology solution to support their needs. Where more in-depth financial advice and support is required, people may be referred

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	on to other, more specialist, Service Providers as appropriate.
Social Inclusion	The Service Provider will work with people to identify areas of interest that are important to them and support them to undertake activities of their choice (i.e., activities related to their likes and interests) For example, art, culture, heritage, physical activities and social contact through specified groups or befriending. Services will be structured in a way which allow people to connect with, and contribute to, their local community
Health Improvement and Wellbeing	The Service Provider will promote wellbeing as a concept in order to build resilience and help keep people mentally, physically, and nutritionally well. Services within this area will include fall awareness and prevention, peer support groups, exercise, stroke preventions and promoting healthy eating. The provision of healthy, hot, and nutritious meal will also form part of this offer. The Service Provider will link in with other Preventative Services to achieve this outcome. The Service Provider will help identify and any network and/or circle of support an individual may have who can contribute to their overall well-being

The above services will include direct provision and/or direct support to enable people to engage and participate as active citizens of Enfield.

This area will require effective management, leadership and strategic planning and partnership arrangement that will support the outcomes of individual and the specification overall aims.

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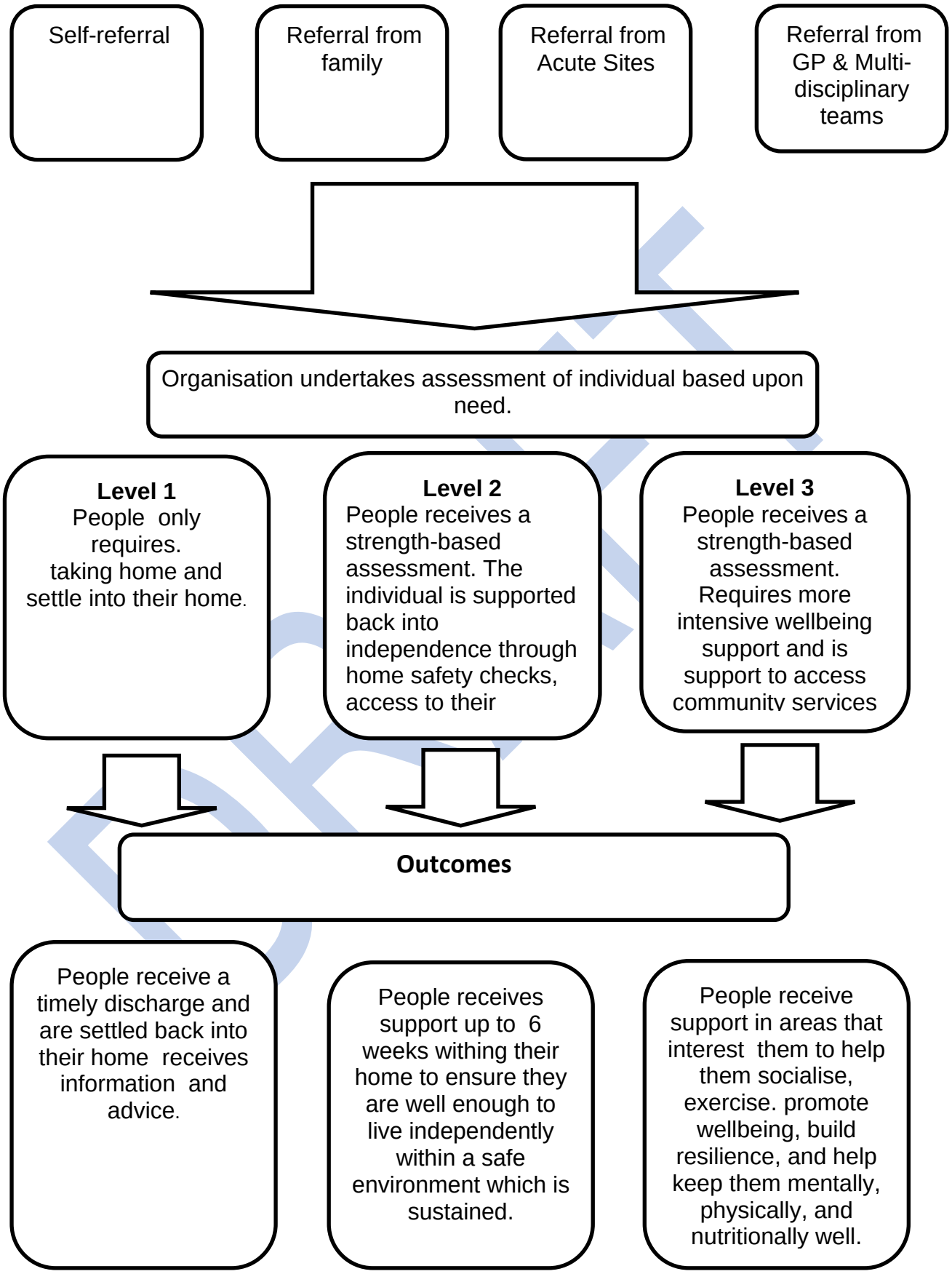
Figure 1 Referral Workflow



8 Contract Value

8.1 Applications are invited up to the value (TBC) per annum.

9 Performance Measures

The above will be measured, alongside basic monitoring data. The Service Provider will have a quality assurance system that is capable of monitoring and assessing provision of the service. The Service Provider will be required to collect data to demonstrate compliance to the required Outcomes and Key Performance Indicators and report their performance on the Council's Pentana Performance Measuring Tool on a quarterly basis. The Service Provider and the Council shall manage the performance of the Service Provider to ensure current delivery meets the required standard. The Council and the service Provider shall together agree methods for collecting and collating KPI data and shall meet on a quarterly basis to discuss performance and outcomes.

Any future additional performance monitoring requirements shall be introduced through discussion with Residents and agreement of the Service Provider and will be informed by the review and development of the Service. Details of the current data returns required are contained in this section of the service specification and shall be updated should any amendments be required during the lifetime of this Contract.

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9.1 Outcome & and Performance Indicator

Outcome	Minimum requirements	Performance measures
• Prevent avoidable hospital admissions	• **TBC**	• Number of people supported in a quarter. • Contact number by hours. • Number of people supported in a quarter by ward. • Number of people re-admitted to hospital compared to previous quarter. • Estimated costs avoided as a result of admissions avoided.
• Through a strength base approach more people feel able to maintain a good standard of wellbeing	• Written qualitative feedback and case studies	• Number of people/patients identifying positive outcomes associated with independence. • Number of peer support groups attended through onward referral
• Improve performance of the discharge process	• Joint partnership working with discharge & Multidisciplinary teams established through Weekly meetings with health professionals within hospital setting or GP practices	• 12 Multidisciplinary Co-production /meetings/networking/events held within a quarter. • No of people/patients who report a positive/improved.

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• Expand volunteers within the community	• Coordinate volunteering opportunities matching opportunities with those looking to volunteer	• 1 Volunteer per quarter • Befriending Service Outcomes within a quarter
Outcome	**Minimum requirements**	**Performance measures**
• People are better informed and can access information using a variety of communication channels.	• More ore people in contact with support service before and after discharge	• Number of onward referrals to other community organisation for on-going well-being needs • Number of take up of new services following referral.
• Peoples are consulted involved and supported through the discharge process	• Contact with people/patients at an earlier stage. • Peoples are consulted involved and supported through the discharge process	• Contact made within 24 hours of referral. • Discharge plan provided to all people/patients
• People are able to live independently and safely in the location of their choosing for longer	• Safe and Connected & Assistive Technology Referrals are made	• Number of take up of new services following referral

9.2 The above KPI will be reviewed within all quarterly monitoring meetings and maybe adapted and/or widen to take account of changes to impacts on changes to any of ASC priorities, service models and service delivery. A full review of KPI will be undertaken annually.

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