

Our Ref: TS/TLR/FOI/0125/1158

Stafford Education & Enterprise Park
Weston Road
Stafford
ST18 0BF

20th February 2025

Sent by email

Telephone: 0300 123 1461

Dear

FOI-0125/1158

Your request for information under the Freedom of Information Act 2000

Thank you for your request for information received on Friday 24th January 2025. We can confirm that the Staffordshire and Stoke-on-Trent Integrated Care Board can provide the following information.

An anonymised copy of this response will be made publicly available on the ICB website.

Please see our responses in blue below:

- 1. Who currently delivers nutrition services for your patients, and do you work with any independent providers?
(example, but not limited to: Acute trusts, community trusts, primary care providers etc.)**

Three of Staffordshire and Stoke-on-Trent System partners deliver nutrition services for our population they are: University Hospital North Midlands, Midland Partnership University Foundation Trust, and Staffordshire Combined Healthcare NHS Trust.

- 2. Do you have a service specification for nutritional category services in your area?
Yes**

- a. Please can you share your service specification?**

This is attached.

- b. If not, is this specification part of a bigger service?**

N/A specification attached.

- c. If not, do you have a framework that a service is measured against e.g. KPI's?**

N/A.

- 3. Nutricia are keen to help the NHS support patients with malnutrition and increase access to NICE approved treatments - how would you like a company like Nutricia to support you?**

Thank you for your offer of support. Can I suggest that your offer of support is offered to our System Partners named in the response to Q1.

Should you require any further information or clarification regarding this response please do not hesitate to contact us. If you are dissatisfied with the response, you are entitled to request an internal review which should be formally requested in writing and must be within two calendar months from the date this response was issued.

To request an internal review

You can request an internal review by contacting the Staffordshire and Stoke-on-Trent ICB FOI team by emailing; staffsstokeFOI@staffsstoke.icb.nhs.uk or by post to the address at the top of this letter within 40 working days of the initial response.

If you are not content with the outcome of your internal review, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the Staffordshire and Stoke-on-Trent Integrated Care Board's FOI complaints procedure.

The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

www.ico.gov.uk

Yours sincerely

Tracey Shewan
Director of Corporate Governance

Encs.

Service Specification No.	A21
Service	Adult Eating Disorders Services – Outpatient/Community
Commissioner Lead	Nicola Bucknall
Provider Lead	Sam Mortimer
Period	01 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.5 National/local context and evidence base

This service specification is consistent with national best practice and operational frameworks using the following policy guidance;

- *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa October 2010*
- [*Guidance for commissioners of eating disorder services;*](#)
- [*http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf*](http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf)
- *Eating Disorder (NICE CG69) Revised May 2017*

Eating disorders (ED) are severe mental illnesses with serious psychological, physical and social consequences. They are characterised by a preoccupation with food and/or weight and body shape and harmful eating habits.

The three most common ED are anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED)

.

Anorexia nervosa (AN) has the highest mortality amongst all psychiatric disorders.

There is a critical window for intervention for people with ED. Recovery is less likely if an ED has remained untreated for more than 3-5 years. Early identification and intervention with access to effective stepped care pathways is of paramount importance to improve clinical outcome and increase cost-effectiveness.

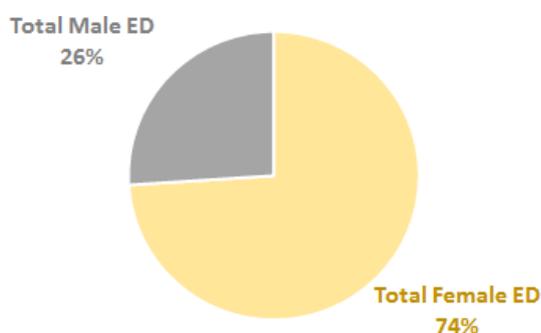
Local strategic context

New care models will see the creation of regional hubs to manage and monitor access to specialist eating disorder inpatient beds. These will be supported by community eating disorder services which will aim to reduce length of stay and out of area placements.

North Staffordshire and Stoke-on-Trent CCGs have identified that there is a gap in services for adults either transitioning from CAMHS services or for adults newly diagnosed with an eating disorder. This has led to admissions to acute hospitals which are unable to fully meet the needs of this patient group or to prolonged and costly OOA placements with limited / no support on discharge.

The new care models for specialist eating disorders will see a shift in resource over time from inpatient to community care.

Estimated Eating Disorder Prevalence in North Staffs & Stoke on Trent Female / Male 18+



Female ED	% of Total	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anorexia	75%	263	263	264	264	263	263	262	262	263
Bulimia	70%	1,496	1,497	1,497	1,496	1,493	1,489	1,486	1,485	1,483
EDNOS	75%	4,308	4,320	4,326	4,330	4,326	4,320	4,316	4,315	4,311
Total Female ED	74%	6,066	6,080	6,087	6,090	6,082	6,072	6,065	6,062	6,063

Male ED	% of Total	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anorexia	25%	88	89	89	89	89	89	89	89	89
Bulimia	30%	636	638	641	643	645	647	649	651	653
EDNOS	25%	1,411	1,416	1,421	1,422	1,422	1,421	1,420	1,421	1,420
Total Male ED	26%	2,135	2,143	2,151	2,154	2,156	2,157	2,158	2,161	2,163

<https://www.beateatingdisorders.org.uk/how-many-people-eating-disorder-uk>

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	ü
Domain 2	Enhancing quality of life for people with long-term conditions	ü
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	ü
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- Ensure no gap between children's and adult services.
- Promote early identification and specialist treatment
- Promote early intervention through education and seamless pathways
- Improve care and recovery rates
- Provision of NICE compliant interventions

Expected patient outcomes include:

- Weight restoration
- Establishing regular and balanced eating patterns
- Stable biochemistry
- Identifying and exploring underlying emotional problems
- Improved psychological functioning

3. Scope

3.1 Aims and objectives of service

The service aims to promote recovery and or promote optimum functioning and quality of life for those individuals whose illness runs a chronic course.

This specialist service provides treatment using a Bio/psycho/social model which is evidence based. Treatment does not only focus on weight and eating but also on the associated / underpinning, psychological issues. Medical monitoring and physical risk management are also an integral part of the treatment.

Psychological models include Cognitive Behavioural Therapy – Enhanced (CBT-E), Cognitive Analytical Therapy (CAT), Psycho-dynamic Psychotherapy, Systemic Family therapy and Interpersonal Therapy (IPT).

The evidence base suggests that the delivery of treatment for most will be through time limited sessions of CBT-E. A number however will require more intensive treatment over a longer period of time, whilst admission avoidance is paramount, for some people due to their complexity, an admission to a specialist eating disorder unit for intensive treatment will be unavoidable.

The aims of treatment are to:

- Establish regular healthy eating patterns
- For the patient to cease compensatory behaviours
- Restore / maintain a healthy weight range
- Manage/improve physical health
- To understand underlying psychological issues and facilitate positive change in these areas

Individuals with less complex presentations will receive care from the locality CMHT. When working with individuals who have more complex presentations and associated co morbidities, there will be close joint working with the Community Mental Health Team (CMHT), ensuring effective liaison and a shared plan of risk management. It will be clear who is Care Coordinator for the patient.

3.2 Service description/care pathway

This specialist service provides a comprehensive assessment and evidence based treatment for those people with a diagnosable eating disorder including Anorexia Nervosa, Bulimia Nervosa, EDNOS and Binge Eating Disorder.

The service will comprise a team of mental health professionals with training in the assessment, risk management and treatment of individuals with eating disorders. The team will be multidisciplinary and will include doctors, nurses, dietician and practitioners with the skills and competencies to deliver NICE approved psychological therapies.

Specialist services for ED work closely with general mental health services for both children and adults, primary care, voluntary sector organisations, and physical healthcare specialists.

The service will provide an agile locality based service model that will work into the existing community teams and primary care, providing education, early intervention and ongoing therapeutic support within localities, offering assessment and intervention for complex eating disorders to include CBT -e, Psychodynamic therapy and guided self-help.

The specialist service will provide psychological time limited interventions with an expectation that once stability has been achieved the service user will, on a needs led basis either be discharged or be supported by generic community mental health teams.

Practitioners within generic community mental health teams will be trained to deliver manualised CBT-e to those individuals with less complex ED presentations and will where deemed clinically appropriate be responsible for the maintenance of underpinning psychological issues.

A community ED service will provide the following:

- Comprehensive psychiatric assessment to include ED psychopathology and identify comorbid mental health and physical conditions. Diagnosis should be discussed with patient, carer and referrer.
- Risk assessment, both psychiatric and physical. This will include organising relevant investigations (e.g. blood tests, ECG, bone densitometry). Clear arrangements should be made with a patient's GP agreeing responsibility for ongoing physical health monitoring.
- Advice and education to the referrer and other teams including when to refer to CEDS.
- A patient-centred, non-judgemental approach utilising motivational interviewing in order to maximise engagement of patients where ambivalence or denial of the difficult aspects of ED are known to influence patients experience of care and outcomes.

- High quality evidence-based psychological therapies for BN and BED (guided self-help-BN/BED; Cognitive Behavioural Therapy CBT-BN, CBT-BED). In the absence of a strong evidence base for specific psychological therapies for AN, services should be able to provide a range of psychological therapies in line with best practice (e.g. SSCM, CBT, Cognitive Analytic Therapy, psychodynamic psychotherapy). Family-focused psychological interventions should also be widely available.

- Intensive community treatment for patients whose condition is deteriorating or not progressing.

- Collaboration with carers/family with careful consideration of patient confidentiality. Carers' needs assessment should be offered, and appropriate advice and support available in addition to family-based interventions such as carers' support groups and family therapy delivered both to individual families and multi-family therapy.

- Nutritional counselling and psychoeducation with the aim of restoring healthy, balanced eating.

Assessment

Comprehensive assessment includes a detailed account of the patient's history, their current mental health, eating disorder symptomatology and physical health incorporating ECG examination and routine blood chemistry. Bone scans will be requested where clinically indicated. Outcome measures are completed at assessment.

A physical health review is undertaken by a specialist with ED knowledge and takes place as part of the initial assessment. The review includes but is not limited to:

- Medical complications of an eating disorder;
- Details of past medical history;
- Current physical health medication, including side effects and compliance with medication regime;
- Lifestyle factors.

The service should have the capacity to provide the following as part of the physical health assessment and ongoing review:

- Height and weight;

- Blood pressure and pulse;
- Skin and mouth condition;
- Squat (SUSS) test;
- ECG;
- Blood test.

Care Planning

Programmes are based on a plan of care devised in collaboration with the patient and where appropriate their carers'. Associated professionals are informed of the care plan and invited to collaborate as necessary. Patients are treated within the care co-ordination system and are regularly reviewed.

Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies

The service will have clear processes around managing risk and safety as well as unattended appointments (including clear follow-up protocols to engage a person and prevent inappropriate discharge)

Treatment and Care

The service recognises the multi-casual aetiology of eating disorders and aims to offer integrated multidisciplinary assessment and treatment.

The service offers various types of treatment options, therapeutic treatments, medical monitoring, dietetic advice and support and advice for carers.

Patients are offered an intensive programme, which does not only focus on weight and eating, but also acknowledges the need to understand the underlying psychological aspects of the disorder. Individual therapy and a variety of group treatments offer our patients an opportunity for exploration of wider issues which include body image, anxiety management and assertiveness training.

Out-patient Treatment Options include:

- Evidence based, focal psychological therapies- CBT-E, IPT, CAT, Systemic Therapy
- Individual Psychotherapy
- Psycho-education
- Dietary analysis and education - The use of micronutrient supplements is recommended in outpatient weight restoration.
- Medical monitoring - A CED service must be equipped to conduct a full medical assessment, including blood tests and ECGs, and receive same-day results to facilitate same-day clinical decision-making.
- The service has the capacity to provide at least weekly blood tests and physical health reviews from an eating disorder specialist for patients at high risk, as defined by MaRSIPAN (Management of Really Sick Patients with Anorexia Nervosa).
- Support for carers
- Relapse prevention

Diagnostic Criteria

- Individuals with eating disorders that significantly affect their physical health and/or their mental and social functioning.
- Moderate/severe eating disorders with high clinical risk.
- A diagnosis of Anorexia Nervosa, regardless of severity as there is little evidence for the treatment of this disorder in primary care. Most patients with Anorexia Nervosa should be managed on an outpatient basis with psychological treatment provided by a service competent in the treatment and assessment of physical risk
- Severe and enduring eating disorders with complex needs requiring continuing care from multiple agencies e.g. drug and alcohol, community mental health, social care.
- Discharged from inpatient treatment should receive psychological/ psychiatric treatment for at least 12 months post- hospitalisation.
- Rapidly losing weight, such as more than 1 kg a week for 1 month or whom are consistently losing weight but over a longer period of time e.g.<0.5kg a week over 3 months.

- Bingeing and/or vomiting/ and or laxatives use/ and or compulsive exercise at least 5 times a week, for 3 months or more.
- Eating disorder and co-morbid depression, and or are at risk of self-harm or suicide
- Failure to respond to evidence based psychological therapies e.g. online CBT-e for mild Bulimia, Binge Eating Disorder, Atypical Eating Disorder or Other Specified Eating Disorder

Response Times

Response times are determined by clinical need/urgency, urgent referrals will be discussed within 5 working day and prioritized for assessment.

Response times are determined by clinical need/urgency and all referrals will be screened. Accepted referrals will then receive treatment within 11 weeks. Priority will be given based on clinical need (those patients who are transferring from CAMH's services, have an early onset of their eating disorder with short illness duration, are pregnant or have type 1 diabetes and those patients with a BMI of less than 14 with rapid weight loss).

Patients who are discharged from hospital to the care of the community team are followed up within 48 hours of discharge

Discharge Process

In general, discharge will be a process agreed through collaborative discharge planning. In some circumstances referrals to other services may be considered.

Once a date has been agreed for discharge, the following should be considered;

1. Any long term follow up plan to be communicated to the patient in terms of how it will be arranged and when it is likely to be carried out. The patient will be asked to complete outcome and satisfaction questionnaires. The data collected will be collated. The satisfaction questionnaires will be inputted onto The Meridian System and used to generate reports. The outcome measures are scored and compared with the measures at assessment.

2. The SU will be supported by the community generic mental health team on discharge from the ED SERVICE if the need is clinically appropriate
3. In cases where the patient is unable to effectively engage in treatment and the physical risks are low then the GP will be asked to take responsibility for monitoring and risk assessment. In some circumstances referrals to other services may be considered.
4. All professionals involved in the patient's care will be informed of the discharge and the care plan. Where the patient is involved with other agencies/services, a detailed summary of the treatment and relapse plan will be sent to them.
5. The patient's GP will be notified of discharge from the service.

Skill Mix

The service has a full multidisciplinary team to deliver NICE concordant care.

3.3 Population covered

Patients over the age of 18 registered with a GP within North Staffordshire and Stoke on Trent CCGs.

When working with university students, the local and home service should work together to ensure seamless continuity of care both in and outside of term time.

3.4 Any acceptance and exclusion criteria and thresholds

The service provides a person centered needs led out-patient/community service for adult patients, both male and female who are predominately aged 18 and over, who suffer with an eating disorder.

However transitional protocols from Childrens ED service will determine the most appropriate team to deliver the required care based on need and not led by age

Inclusion criteria

- Individuals with eating disorders that significantly affect their physical health and/or their mental and social functioning
- Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity

- Moderate/severe eating disorders with high clinical risk.
- A diagnosis of Anorexia Nervosa, regardless of severity as there is little evidence for the treatment of this disorder in primary care.
- Severe and enduring eating disorders with complex needs requiring continuing care from multiple agencies e.g. drug and alcohol, community mental health, social care.
- Individuals discharged from inpatient treatment should receive psychological/ psychiatric treatment for at least 12 months post- hospitalisation.
- Rapidly losing weight, such as more than 1 kg a week for 1 month or whom are consistently losing weight but over a longer period of time e.g.<0.5kg a week over 3 months.
- Bingeing and/or vomiting/ and or laxatives use/ and or compulsive exercise at least 5 times a week, for 3 months or more.
- Eating disorder and co-morbid depression, and or are at risk of self-harm or suicide
- Failure to respond to evidence based psychological therapies e.g. online CBT-e for mild Bulimia, Binge Eating Disorder, Atypical Eating Disorder or Other Specified Eating Disorder

Exclusion Criteria

- Mild eating disorders which do not cause significant distress, considerable physical risk or impairment in the service user's social, occupational and other important areas of functioning. These individuals would be most appropriately referred to initially try online guided CBT-e and supported by generic community mental health teams.
- Loss of appetite, psychogenic disturbance of appetite or other conditions that involve significant weight loss but which are due to physical illness or other psychiatric conditions such as anxiety disorder.
- Morbid obesity (i.e. in the absence of an additional diagnosis of an eating disorder such as Binge Eating Disorder or Bulimia Nervosa).
 - Primary substance misuse
 - Weight loss due to primary depression
 - Weight loss due to organic disease
 - Obesity in the absence of binge eating disorder

- Abnormal eating patterns due to psychosis / learning difficulties
- Specific food phobias

Days / Hours of Operation

The service is predominantly a 9 am-5 pm service, operating Monday to Friday **However this will be developed through a staged approach over next 3 years to support intensive home support and out of hours support to prevent admissions to specialist care**

Referral Process

Referrals will be accepted through a single point of access and will be accepted from General Practitioners and other healthcare professionals with General Practitioner approval.

All referrals are screened by senior clinicians. A decision will then be made as to both the appropriateness of the referral and, if accepted, the degree of urgency, based on clinical needs generally relating to BMI, rate of weight loss or instability of blood chemistry.

Local referral pathways and protocols assist in the referral process and in treatment planning.

Referral criteria includes the following features;

- Rapid and / or sustained weight loss
- Deliberate, poor nutritional intake
- Objective binge eating
- Use of compensatory behaviours in order to avoid weight gain i.e. self-induced vomiting, laxative abuse, diuretic abuse and excessive exercising
- Body image disturbance / distortion
- Drive for thinness
- Morbid fear of fatness
- Persistent failure to meet appropriate nutritional /energy needs / significant nutritional deficiency

3.5 Interdependence with other services/providers

- NHSE commissioned Eating Disorders Inpatient provision

- CMHT – will provide support for people with Eating Disorders

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- Eating Disorder (NICE CG009)
- Eating Disorders Quality Standard (QS175)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Management of really sick patients with Anorexia Nervosa Oct 2014 Royal College of Physicians (MARSIPAN).
- [Guidance for commissioners of eating disorder services](http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf); Joint Commissioning Panel for Mental Health <http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf>
- CCQI Quality Standards for Adult Community Eating Disorder Services, First Edition, May 2019, Royal College of Psychiatrists

https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/eating-disorders-qed/qed-community-standards---first-edition.pdf?sfvrsn=63c956ba_2

- Adult eating disorders: community, inpatient and intensive day patient care - Guidance for commissioners and providers, National Collaborating Centre for Mental Health, August 2019
- Transition from children's to adults' services (2016) NICE quality standard 140.

4.3 Applicable local standards

- Inpatient case conference / referral process / protocol
- Risk assessment and management
- CPA policy
- Local transition protocol from CYP to adult services

5. Applicable quality requirements and CQUIN goals

5.19 Applicable Quality Requirements (See Schedule 4)

- Standardised measures should be used to measure outcome (e.g. Eating Disorder Examination Questionnaire, EDE-Q; CORE; HONOS; Clinical Impact Assessment Questionnaire, CIA) recovery outcomes (e.g. returning to work/college).
- Patient satisfaction with services should also be evaluated.
- A clinical audit of compliance with NICE quality standards will be undertaken in the first year of service delivery
 - [Statement 1](#) People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults.
 - [Statement 2](#) People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment.
 - [Statement 3](#) People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment.
 - [Statement 5](#) People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together.
 - [Statement 6](#) People with eating disorders who are moving between services have their risks assessed.

Quality network for eating disorders (QED)

This is an initiative of the College Centre for Quality Improvement. A quality assurance framework has been developed to provide a set of both core and specific standards.

The standards can be found at:

www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/eatingdisordersservices/qed.aspx

5.20 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at: within the locality premises of the Trust with a HUB available in the North and the City for team and MDT meetings

Service Specification No.	CS_19
Service	Dietetic Service
Commissioner Lead	Sharon Cooper
Provider Lead	Adam McKeown / Steve Foster
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.1 National/local context and evidence base

Malnutrition is a state in which a deficiency, effects on tissue/body form (body shape, size and excess or imbalance of energy, protein and other nutrients causes measurable adverse composition), function or clinical outcome.ⁱ Although the term 'malnutrition' can encompass both over-nutrition/obesity and under-nutrition.

National research indicates that one in ten people over 65 living in their own homes are malnourished or at risk. Malnutrition is estimated to be higher in other settings: 40-45% in residential and nursing care homes and 25% amongst hospital patients. Research also shows that malnourished people: see their GP twice as often, and stay in hospital more than three days longer than those who were well nourished.

Methods to improve or maintain nutritional intake are known as nutrition support. These include:

- Oral nutritional support – for example, fortified food, additional snacks and/or sip feeds;
- Enteral tube feeding – the delivery of a nutritionally complete feed directly into the gut via a tube;
- Parenteral nutrition – the delivery of nutrition intravenously.

Malnutrition is a common problem with more than 3 million people at any one time in the UK malnourished.ⁱⁱ

The benefits of improving nutritional care and providing adequate hydration are immense, especially for those with long term conditions and problems such as stroke, pressure ulcers or falls. The evidence shows clearly that if nutritional needs are ignored health outcomes are worse and meta-analysis of trials suggests that provision of nutritional supplements to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%.ⁱⁱⁱ

1.2 Local Context

1.2.1 Collectively Cannock Chase, South East Staffordshire & Seisdon Peninsula, Stafford & Surrounds Clinical Commissioning Groups are the responsible health care commissioners for a population of 487,000 (133,000, 210,000 and 144,000 respectively).

Staffordshire County Council (Public Health) has commissioned a healthy lifestyle service with Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP). The healthy lifestyle service offers non-clinical lifestyle behaviour change support around stopping smoking, weight management, and reducing alcohol intake. The healthy lifestyle service will be the predominant lifestyle service in Staffordshire; the dietetic service will work in addition to the lifestyle service and shall only manage and support individuals that meet the acceptance criteria.

1.2.3 For information the Healthy Lifestyle Service offers:

- Tailored and structured motivational support that will address single and multiple lifestyle risk behaviours: smoking, excess weight and harmful alcohol intake.
- Provision of evidence based interventions offering
- Up to 6 alcohol brief intervention sessions.
- 10-12 weeks non-clinical weight management support.
- 10-12 weeks stop smoking support with access to stop smoking medications.
- Up to 12 months support delivered using a variety of contact methods ranging from face to face/ telephone / online / peer support.
- A link to the Healthy Staffordshire Hub for access to information, advice, guidance and access to community prevention programmes.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- 2.2.1 The Service shall not replicate those services commissioned within the Lifestyle Services for Staffordshire;
- 2.2.2 The Service shall provide specialist dietary support to the population served as indicated in the acceptance criteria;
- 2.2.3 The Service shall work in multidisciplinary teams across specialist services to manage patients in an integrated manner, i.e. specialist diabetes services and frail elderly services, and shall not operate as a standalone service;
- 2.2.4 Behaviour change shall be a key outcome for the Service intention;
- 2.2.5 Reduction of individuals on prescribed ONS's (Oral Nutritional Supplements);
- 2.2.6 Discharge Service Users to supporting services when clinically appropriate.

3. Scope

3.1 Aims and objectives of service

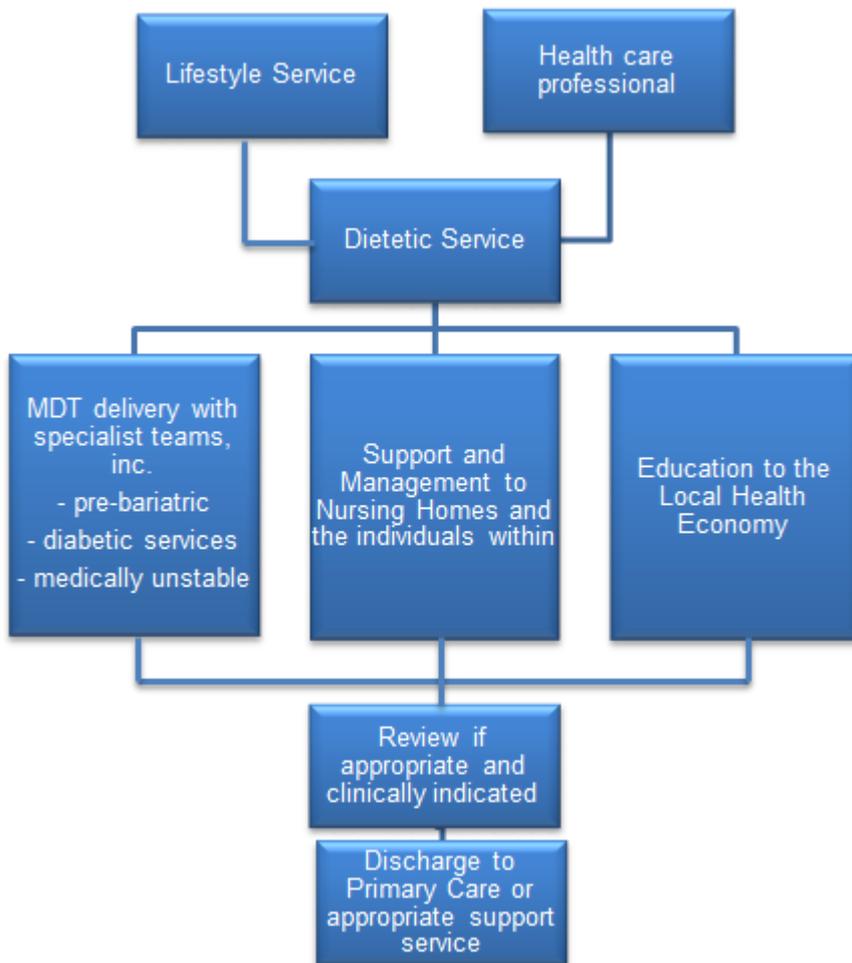
The Service shall appropriately triage referrals and ensure that where appropriate individuals are referred to the Lifestyle Service provided by Staffordshire and Stoke on Trent Partnership Trust (SSOTP);

The Service shall work with Service Users to develop individual care plans that meet the needs and objectives of the individuals;

- The Service shall support individuals to stabilise and maintain their medical condition where dietary factors are a contribution to an exacerbation of their condition;
- The service will provide specialist dietetic interventions to patients receiving home enteral nutrition.
- The Service shall support specialist teams to deliver education and dietary management where it is part of the individuals care plan, i.e. Specialist Diabetes Services, those on ONS and enteral tube feeding;
- The Service shall work within multidisciplinary teams to deliver integrated care where possible;
- The Service shall support medically obese individuals with their nutrition when their condition is medically unstable;
- The Service shall support Nursing Homes to facilitate the appropriate dietary management for the frail elderly population. This shall include MUST (Malnutrition Universal Screening Tool) score training to Nursing Homes to enable identification of individuals dietary needs and support;
- The Service shall carry out sip feed audits in partnership with the medicine management teams of the CCG's at least annually and work to reduce the prescribing of unnecessary ONS's (Oral Nutritional Supplements);
- The Service shall educate and support community services to deliver low level dietary education that will empower patients to self- manage and access the Lifestyle Service.
- The Service shall manage and support pre-bariatric individuals in a multidisciplinary approach to ensure all non-surgical attempts to manage weight management have been exhausted; Service Users who attend the Service as part of the bariatric surgical pathway, the Service shall offer a programme of care and support in line with NHS England policy (a minimum programme of twelve months for those who have a BMI >40kg m² and six months supported for those who have >50kg m²). A full assessment will be made of every individual prior to being referred for bariatric surgery. The importance of behaviour change will be a key outcome of the service intervention.

3.2 Service description/care pathway

The Provider shall accept referrals, including those which have been made via the Map of Medicine pathway.



Population covered

The Provider shall deliver this service for patients registered with practices within the following Clinical Commissioning Groups:

- South East Staffordshire & Seisdon Peninsula Clinical Commissioning Group
- Cannock Chase Clinical Commissioning Group;
- Stafford & Surrounds Clinical Commissioning Group;

3.3 Any acceptance and exclusion criteria and thresholds Eligibility Criteria

- Aged 18 years or over;
- Medically unstable individuals whereby dietary factors are a contribution to an exacerbation of their condition:-
 - Type 1 diabetes where dietetic service is not provided through alternative specialist services
 - On a texture modified diet or thickened fluids
 - BMI below 18 with clinical/dietary concern
 - MUST 3 and above
 - MUST score ≥ 2 and completed 6 Steps to Appropriate Nutritional Care in Adults with no improvement
- Patients requiring enteral feeding
- Irritable Bowel Syndrome – Symptomatic
- Inflammatory Bowel Disease - Symptomatic
- Diverticular disease – symptomatic

- On anti-obesity medication being considered for surgery BMI>50
- Need for specialist dietary interventions for weight loss such as low calorie and very low calorie diets

Patient's from high risk groups as indicated in this list stepped up from Lifestyle service

- Allergy/intolerance/Coeliac Disease/Dermatitis Herpetiformis where dietetic input is needed
- Patients with mental health conditions/learning disabilities requiring specialist dietetic input for weight loss on the following medication: -
 - Sodium Valporate
 - Lithium
 - Clozapine
 - Olanzapine
 - Risperidone
 - Ziprasidone
 - Prednisolone
 - Nortriptyline
 - Doxepine
 - Amitriptyline
 - Gabapentin
 - Pregabalin
 - Mirtazapine
- Type 2 Diabetes - treated with insulin or oral hypoglycaemic agents
- Heart Failure moderate to severe New York Functional classification 3 and 4

Step up to Specialist Dietetic Service considered after 3 months in Lifestyle Service when client has not achieved targeted weight loss (5%):

- Clients referred for bariatric surgery or previously had bariatric surgery
- Chronic Kidney Disease 3b
- Cushing's syndrome
- Lymphoedema / Lipoedema
- Women with polycystic ovary syndrome
- History of disordered eating – not currently under specialist care
- Patients fully engaged in the Lifestyle Service who have failed to lose weight at 3-6 months at GP's discretion/need for endocrinological review.

All patients will be stepped down from the specialist dietetic service to community based services at the earliest opportunity.

Exclusion Criteria:

- Under the age of 18 years;
- Requiring specialised commissioned services. i.e. eating disorders;
- Individuals receiving renal replacement therapy and Chronic Kidney Disease stage 4-5
- Support to inpatients services
- Patients who can be seen in the Lifestyle Service
- Patients being seen in other specialist services with dietetic intervention

3.3 Interdependence with other services/providers

The Provider shall be required to work with the following providers:

- Public Health Lifestyle Service
- General Practice;
- Pharmacists;
- Staffordshire County Council;
- Acute Service Providers;
- South Staffordshire & Shropshire Healthcare Trust
- Local Voluntary Service (Age UK)
- Care Homes

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE: Nutrition support in Adults: oral nutrition support, enteral tube feeding and parenteral nutrition, CG32. <http://guidance.nice.org.uk/CG32/niceguidelines/pdf/English>
<http://guidance.nice.org.uk/CG32/QuickRefGuide/pdf/English>
- NICE: Quality standard for nutrition support in adults QS24 November 2012: <http://guidance.nice.uk/qs24>
- NICE: Obesity: identification, assessment and management of overweight and obesity in children, young people and adults CG189

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- British Dietetic Association www.bda.uk.com
- British National Formulary: www.bnf.org.uk
- Cochrane Collaboration (2007). 'Dietary Advice for illness-related malnutrition in adults (review)': www.cochrane.org
- Malnutrition Universal Screening Tool (MUST): www.bapen.org.uk
- Managing Adult Malnutrition in the Community: www.malnutritionpathway.co.uk

4.3 Applicable local standards

Staffordshire Every Mouthful Matters, Nutritional Guidelines

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Not Applicable

Service Specification No.	CS_23
Service	Specialist Adult Dietetic Services – Nutrition Support (Adults) – Uttoxeter Area only - East Staffs Clinical Commissioning Group
Commissioner Lead	Emily Davies
Provider Lead	Steve Foster
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Need

1.1 National/local context and evidence base

Malnutrition is “a state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes measurable adverse effects on body composition, function (including social and psychological) and clinical outcome.” (NICE, 2017).

Malnutrition is common in the UK, affecting more than three million people (AHP, 2012) at any one time. Research indicates 1 in 3 patients admitted to acute care will be malnourished or at risk of becoming malnourished and 35 percent of individuals admitted to care homes will be affected. The annual health costs associated with malnutrition alone are estimated to exceed £13 billion (Elia & Russell for BAPEN, 2009). Reducing the number of patients admitted to acute care with malnutrition, including those from care homes would lead to a resultant reduction in acute care costs.

An additional benefit to this is the reduction of pharmaceutical waste, resulting in better use of scarce resources. Malnourished people are likely to see their GP twice as often, and stay in hospital more than three days longer than those who are well nourished. Meta-analysis of trials suggests that provision of nutritional supplements to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%.

Uttoxeter is a town within the geographical area of East Staffordshire CCG, with a population of around 13,000 people. The Specialist Adult Dietetic Service providing Nutrition Support will provide a range of services for adults within the inclusion criteria, as well as additional support to nursing homes on recognising malnutrition.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes;

- For service users to achieve their nutritional plan by discharge;
- To offer appropriate care home (both residential and nursing) staff training on the Malnutrition Universal Screening Tool [MUST] that would enable at least one member of staff from each care home to attend;
- To promote the use of nutritional screening tools for identification of adults “at risk” of malnutrition and the use of local action plans to treat malnutrition;

Activity Numbers

- Number of rapid reviews completed by service staff members (this is the review of patients already on supplements who have not been assessed by a dietitian previously)
- Number referred to the service
- Number of inappropriate referrals
- Number of contacts after referral - new/review
- Type of contact – face to face/telephone
- Number of MDT contacts – e.g. MDT meetings/case conferences/safeguarding meetings/contacts with other professionals as part of care, e.g. DNs/SALT/GP etc.
- Number and type of training sessions delivered
- Percentage of service users who have a care plan

3. Scope

3.1 Service Aims and Objectives

To support the appropriate use of oral nutrition support for adults residing in the community, specifically housed bound and nursing/residential care home service users who meet the referral criteria.

The service will provide patient-centred evidence-based interventions for adults (and guidance and support for their carers / families) who are identified to be at a high risk of malnutrition in accordance with the Staffordshire Nutrition Support Guidelines:

- BMI below 18.5 with clinical/dietary concern
- MUST 3 and above
- MUST score >2 and completed 6 Steps to Appropriate Nutritional Care with no improvement

The service will offer education, to health and social care staff, including care home staff, as deemed appropriate and reasonable to support clinical activity, on the identification and treatment of malnutrition. This will include leading and/or supporting resource development (e.g. patient information literature, education tools).

Training provided will include the use of the Malnutrition Universal Screening Tool (MUST) which should be used to identify those at risk of malnutrition as well as education on meeting nutritional requirements through the food first approach in line with the Staffordshire Nutrition Support Guidelines. The Staffordshire Nutrition Support Guidelines set out in detail the use of MUST and how high risk patients are identified. Training provision for care/residential home staff is a key aim of this service.

Subject to capacity, a review of housebound/nursing home patients who have been prescribed supplements and are not under the care of a dietitian will take place with the aim of ensuring that supplements are prescribed appropriately. This will require support from medicines optimisation at the CCG and GP surgeries in order to identify the patients requiring dietetic review.

3.2 Service description/care pathway

3.3 Triage & Screening of Patients

The hub, located at Becroft Court in Cannock, will triage all referrals within 1 working day of receipt and offer appropriate dietetic response within the capacity of the service. Appropriate here means within the scope of the service. This will be either sign posting to information or booking

a dietetic assessment at the patient's place they call home. If deemed appropriate initial advice may be provided by telephone.

- 3.4 Appointments will be offered between 9am – 5pm across Monday to Friday excluding Bank Holidays. All patients will be contacted within 5 working days of the referral being triaged either by letter or phone depending on the urgency of the referral. Urgency is determined by clinical judgement based on the clinical needs of the individual, e.g. MUST score/diagnosis etc.

Comprehensive Nutritional Assessments

- 3.5 Each patient meeting the service referral criteria shall have a relevant patient centred nutritional assessment. This will cover current dietary and fluid intake, anthropometrics, and review of relevant biochemistry, clinical conditions and symptoms, physical activity levels, access to food and fluid, social circumstances which affect nutritional status.

Working within Multidisciplinary Teams to deliver Integrated Care

- 3.6 To deliver effective care for our most complex patients this needs to be within a multidisciplinary team. The dietetic team will continue to build on their current multidisciplinary team working and make full use of emerging technology such as RIO. The service will actively seek to engage GPs in their care and link closely with teams both internal and external to SSOTP.

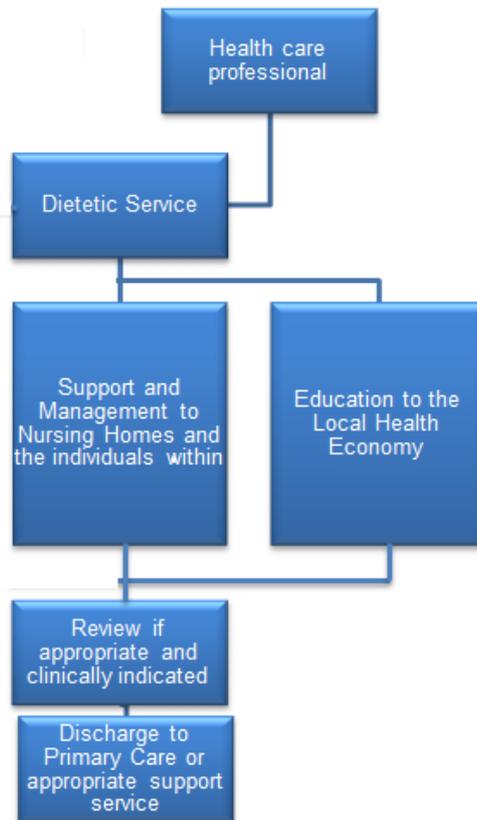
Providing Nursing Home Support The service will provide nutritional assessment and monitoring for all referred patients living in care with the addition of actively working with the care provider to empower them to take a 'Food First Approach' to malnutrition to drive down the cost and inappropriate use of oral nutritional supplements.

The service will focus on MDT delivery and will aim to work closely with Partner Organisations to support the care provider.

- 3.7

Care Pathway

3.8



3.9

3.1 Population covered

3.1

0 People registered with a GP within the Uttoxeter area only.

GP surgeries:

Mill View
North Gate
Balance Street
Abbots Bromley

If a patient is registered with a Uttoxeter GP surgery, but resides outside the Uttoxeter area, then nutritional support will still be offered as per the specification. Training will not be offered to staff in the care home where the service user resides owing to reasons of capacity and practicality.

3.1 Any Acceptance and Exclusion Criteria and Thresholds

3.1

1

Inclusion Criteria

Adults who are housebound in their own homes/in nursing and residential homes and identified to be at a high risk of malnutrition in accordance with the Staffordshire Nutrition Support Guidelines:

- BMI below 18.5 with clinical/dietary concern
- MUST 3 and above
- MUST score >2 and completed 6 Steps to Appropriate Nutritional Care with no improvement

Exclusion Criteria

3.1
2

- Under the age of 18 years
- Non housebound individuals who can therefore be seen by other commissioned services in a clinic setting
- Requiring specialised commissioned services. i.e. eating disorders
- Individuals receiving renal replacement therapy and Chronic Kidney Disease stage 4-5
- Support to inpatient services
- Patients being seen in other specialist services with dietetic intervention
- Any adult requiring dietetic intervention (eg: Type 1 and 2 diabetes, gastrointestinal conditions such as irritable bowel syndrome, food allergy) who are not also identified to be at high nutritional risk or requiring immediate dietetic intervention for oral nutrition support.

House bound is defined here as

‘a patient to whom the GP Practice would normally offer home visits because this is the only practical means of enabling the patient to consult a GP face to face.’

The service extends this definition further as

“A person who has proven morbidity and who is genuinely unable to leave their home, either on a short term or long term basis. Where it is apparent that the patient could be assisted to, or is able to attend clinic or surgery then this should be discussed with the individual, facilitated and promoted.”

Principle

3.1
3

- Ultimate responsibility to determine whether a patient requires a home visit rests with the assessing clinician.
- Each patient’s eligibility for home visits will be individually determined.
- Individual circumstances will be monitored and where an individual and/or Health care Professional assesses that the patient’s needs have changed due to either an acute onset of illness or gradual deterioration in their conditions, the patient’s housebound status will be reviewed.”

Any patients with an inappropriate referral, or who do not meet the inclusion criteria, will be signposted back to their GP.

Interdependence with other services/providers

The Service cannot work in isolation and must work closely with partners to improve the nutritional health and well-being of adults identified at nutritional risk who are registered with GPs in the Uttoxeter area. The list of applicable surgeries can be found at the 3.8 “Population Covered”.

Key stakeholders include patient/public, general practitioners and the wider primary health care team, health and social care workers, community pharmacists, community matrons and clinical nurse specialists, pharmacy advisors, community hospitals (including independent providers), secondary care (including discharge liaison), local authority, care homes, local voluntary support and carer groups, national support groups, private companies (e.g. enteral feeding and nutritional supplement providers).

The service provider will have interdependencies with GP practices, Burton Hospital Foundation Trust, Virgin Care Services Limited, residential and nursing home providers, carers and ESCCG Medicines Optimisations Team.

Response Time and Prioritisation

The hub will triage all referrals within 1 working day of receipt and offer appropriate dietetic response within the capacity of the service. If deemed appropriate initial advice may be provided by telephone.

Appointments will be offered between 9am – 5pm across Monday to Friday, excluding Bank Holidays.

All patients will be contacted within 5 working days of the referral being triaged. Contact will be either by letter or phone depending on the urgency of the referral.

All patients referred will be provided with food first advice and requested to be started on supplements at this point as per the Nutrition Support Guidelines.

Routine referrals- all patients are to be assessed within 4 weeks of the receipt of the referral at the relevant hub.

Urgent referrals- patients classified as urgent MUST>4 will be offered a contact within 2 weeks.

Discharge

Patients will be discharged back to their GP once their nutritional care plan is established for ongoing monitoring and review.

4. Applicable Service Standards

4.1 **Applicable national standards (e.g. NICE)**

National Institute for Health and Clinical Excellence – various including NICE Clinical Guideline 32 (2017).

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. British Dietetic Association)

4.3 **Applicable local standards**

- Staffordshire Nutrition Support Guideline
- Appropriate Prescribing of Oral Nutritional Support Guidelines

5. Applicable Quality Requirements and CQUIN Goals

All quality monitoring measures are to be reported on quarterly.

Quality requirements are included in schedule 4 and schedule 6 of the Standard NHS Contract and pertain specifically to the Uttoxeter Adult Nutrition Support Service.

6. Location of Provider Premises

The Provider's Premises are located at:

The booking hub is located at Beecroft Court Rear Block C, Beecroft Road, Cannock, WS11 1JP.

htmNational Institute for Clinical Excellence (NICE). Nutrition Support in Adults (32) Cost Saving Guidance (2017)
<https://www.nice.org.uk/guidance/cg32/Clinical>

Excellence (NICE), (2012). Nutrition Support In Adults QS24. <http://www.nice.org.uk/guidance/qs24/chapter/Quality-statement-1-Screening-for-the-risk-of-malnutrition>

A. Service Specifications

Service Specification No.	DSE-01
Service	Diabetes Structured Education
Commissioner Lead	Lynn Millar
Provider Lead	Upkar Jheeta - Head of Business & Service Development (Staffordshire & Stoke-on-Trent Care Group)
Period	01 April 2023 – 31 March 2024
Date of Review	As required

1. Population Needs

1.1 National/local context and evidence base

Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year¹; the number of people in the UK with diabetes is also increasing and is projected to rise from 3.1m to 3.8m by 2020².

Coinciding with the increasing obesity levels in the UK it is expected that the incidence of Type 2 Diabetes (which accounts for approximately 90% of diabetes in the UK³) will increase; as a result of this it is estimated the number of people with diabetes in the UK will rise to 4.6m by 2030⁴. This makes it the long-term condition with the fastest rising rate of prevalence⁴.

Based on estimates from Diabetes UK the current cost to the NHS as a result of diabetes is currently £205m, predicted to increase to £252m and £328m by 2020 and 2030 respectively. Around 80% of these costs are due to complications (e.g. inpatient days).

1.2 Local Context

One in 20 people with diabetes also incurs social care costs due to complications such as heart disease, stroke, blindness, kidney disease and amputations, with 75% of these resulting in residential and nursing care and the remaining being community based. Estimates from Diabetes UK suggest that the total cost of caring for people with diabetes in adult social care settings in Staffordshire and Stoke-on-Trent is £17m per year, predicted to rise to £21m and £27m by 2020 and 2030 respectively. Research also indicates that around one in four people living in care homes have diabetes.

Diagnosed diabetes prevalence in both Staffordshire and Stoke-on-Trent has increased from 5.9% (43,700 cases) in 2006/07 to 7% in 2014/15 (64,600 cases).

In November 2015 the Staffordshire Health and Wellbeing Intelligence group produced a report on Diabetes Prevention. This report indicates that with improvements in awareness, early diagnosis and recording; and the current obesity trend; the prevalence of Diabetes across Stoke-on-Trent and Staffordshire will continue to increase and will be 8.7% by 2020 and 11.3% by 2030 (5).

The current prevalence rate in England for diabetes is 6.8%; as indicated in the figures below both East Staffs are 7.2% and are higher than the national average. It should also be noted that this does not take account of the many people who remain undiagnosed and therefore these figures could be potentially be much higher.

Diabetes: Quality and Outcomes Framework (QOF) prevalence (aged 17+) 2017/18

QOF data (2017/18) shows that diabetes prevalence in East Staffordshire (7.2%) is statistically higher than the England average (6.8%) in 2017/18, over the past 3 years the diabetes register in East Staffordshire is increasing on average by 270 patients per year.

Optimising control of blood glucose levels and blood pressure can reduce the impact of complications significantly. Better blood glucose control reduces the risk of major diabetic eye disease by a quarter and early kidney damage by a third.

The necessary lifestyle changes, the complexities of management and the side effects of therapy make education for people with diabetes a central part of diabetes management. Diabetes usually falls into the following categories; however, there are other less common forms including for example MODY, LADA (this list if not exhaustive):

Type 1 diabetes (T1DM) develops if the body cannot produce any insulin. It usually appears before the age of 40 years, especially in childhood. It is the less common of the two types of diabetes. It cannot be prevented, and it is not known why exactly it develops. Type 1 diabetes is treated by daily insulin doses by injections or via an insulin pump.

Type 2 diabetes (T2DM) develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). Type 2 diabetes is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin can be required.

Ten per cent of people with diabetes have T1DM, and 90 per cent have T2DM

Structured education and self-management programmes aim to improve outcomes by:

- Stressing the importance of acceptance of diabetes and addressing the person's health beliefs;
- optimising their metabolic control;
- addressing their cardiovascular risk factors (helping to reduce the risk of complications);
- helping them to change their behaviour (such as increasing their physical activity);
- improving their quality of life and reducing any depression.

Patient centred care is key for people with Diabetes. Self-care can be a complex issue, and it is vital that people with diabetes have the skills they need to manage their condition effectively. This highlights the need for patient education to be a key part of any local diabetes service.

References

1. National Diabetes Audit Mortality Analysis 2007-2008 – NHS Information Centre, 2011
2. The management of adult diabetes services in the NHS - National Audit Office; 2012 in POSTNote Number 415 Preventing Diabetes, July 2012
3. Diabetes in the UK 2012: Key statistics on diabetes, Diabetes UK, 2012
4. Commissioning Excellent Diabetes Care: an at a glance guide to the NHS Diabetes Commissioning Resource – NHS Diabetes and Diabetes UK, February 2012, Second edition

Staffordshire and Stoke-on-Trent Focus on Healthy Lifestyles – Diabetes Prevention, Staffordshire Observatory November 2015.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	

Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Local defined outcomes

- Improve patient knowledge, health beliefs, and lifestyle changes to enable them to self-manage their diabetes condition through:
 - Improved glycaemic control
 - Reduced BMI, cholesterol & blood pressure
 - Increased levels of physical activity
 - Increased smoking cessation rates
 - Lower levels of depression
- Increase participant's self-efficiency, increase motivation and attitudes to self-care thereby reducing complications / crisis management and unplanned use of secondary care health services.
- Reduce the need for, and potentially better targeting of, medication and other items, for example blood testing strips.
- Reduce inequalities and improved access to educational support, especially among black and minority populations.
- Increased patient choice and improving partnership working, patient experience and engagement.
- Increased cost effectiveness of services.
- Reduction in visits to General Practices and missed appointments.
- Patients are able to set their own goals and develop their own personal action plan regarding future diabetic management

3. Scope

3.1 Aims and Objectives of Service

Provide an accredited programme of diabetes education for all adult patients diagnosed with diabetes within the East Staffordshire CCG area to support them in the effective self-management of their condition. Programmes should be delivered by appropriately trained educators, be evidence based and suit the needs of the individual. Programmes should have specific aims and learning objectives to support individuals plus family/carers enabling them to take increasing control of their own condition and integrate effective self-management into their daily lives.

High-quality structured education can have a profound effect on biomedical outcomes, and outcomes and can significantly improve quality of life and satisfaction for patients with diabetes.

This service shall:

- Deliver standardised high quality, evidence based structured education for adults who have diabetes within East Staffordshire CCG that is consistent with NICE and all national/local standards and guidance on how the programmes are delivered and suits the need of the person.
Have specific aims and learning objectives, supporting the person and their family members and carers in developing attitudes, beliefs, knowledge and skills to self-manage diabetes.
- Have a structured curriculum that is theory-driven, evidence-based and resource-effective, has supporting materials, and is written down.
- Be delivered by trained educators who have an understanding of educational theory appropriate to the age and needs of the person, and who are trained and competent to

deliver the principles and content of the programme. All members of the healthcare team must be familiar with the content of local education programmes, to ensure that consistent advice is given to all patients.

- Be quality assured, and reviewed by trained, competent, independent assessors who measure it against criteria that ensure consistency.
- Regularly audit attendance.
- Empower adults with diabetes to manage their condition by supporting the development of self-management/self-care skills to reduce the risk of people with diabetes developing complications.
- Have mechanisms in place to maximise attendance at each education session and reduce the overall number of non-attenders and dropout rates.
- Refer patients to IAPT services for psychological support for adults diagnosed with diabetes aimed at improving mental wellbeing by supporting the development of self-management / self-care skills.

3.2 Service descriptions/care pathway.

1) Structured Education for patients diagnosed with T2DM

The majority of these patients will be under the care of primary care.

The service shall deliver accredited structured education sessions in accordance with current national guidance to meet the requirements of patients diagnosed with T2DM and be offered to 100% of all adults referred to the service.

The Structured Education Programmes shall will satisfy the following criteria:

- Have a person centred, structured curriculum that is theory driven and evidence based, resource effective and efficient, has supporting materials and is written down.
- Be responsive to the needs of service users and carers, and provide equitable access, ensuring that service users are treated with dignity and respect, are fully informed about their diabetes management and are able to make decisions about their diabetes management in partnership with healthcare professionals.
- Be flexible to suit the needs of the individual (for example including the assessment of individual learning needs, but this does not include individual education sessions as the service is group based) and to cope with diversity, for example meeting the cultural, , cognitive and literacy needs in the locality.
- The programme shall help people with diabetes, and their carers to improve knowledge of diabetes and understand the aims of its management to prevent complications.
- Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, language barriers. The Provider should make adequate and reasonable provision for translators , carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.

Referral Route

Referrals will be accepted from the following Health Professionals:

To note: Referrals must provide all information required on the referral form including H1bA1c, cholesterol, BMI, blood pressure, and date of diagnosis. If not complete the service will return the referral.

- GP
- Advance Nurse Practitioner
- Practice Nurse
- Tier 3 Community Specialist Team
- Case Manager
- Secondary Care

Service Response Times

Patients diagnosed with diabetes will be offered an appropriate accredited structured education programme at time that suits the patient, this will be an opt in letter, if there is no contact after four weeks patients will be discharged.

Confirmation of the booking should be issued to all patients within 5 days of the booking.

Providers shall establish protocols for patients that have not responded and if appropriate patients will be booked onto the course or offered My Desmond

Did Not Attend (DNAs)

The Provider will be responsible for following up any patient that does not attend a scheduled education session to establish the reasons for this and to offer an appropriate alternative, such as online resources, GP's must be informed in writing of any DNAs and the failure of any patient to complete an education session.

Attend and not completed

This refers to patients that have attend the course but have left part way through the course

3.3 Population covered

The service will be available to all adults who are registered permanently, or temporarily with a GP practice located in East Staffordshire CCG footprint, at the time that care is required.

3.4 Any acceptance and exclusion criteria and

thresholds Acceptance Criteria

- All patients over 18 years of age
- Newly diagnosed diabetics with Type 2 diabetes
- All pre-existing patients with Type 2 diabetes who have not previously partaken in structured education on an annual basis although these are see in other services
- People with poorly managed pre-existing diabetes - IFCC ≥ 86 .

Exclusion Criteria

- Adults living outside of East Staffs who are not registered with a local GP
- Patients with impaired glucose tolerance
- Children & adolescents
- Severe & acute complications related to their diabetes
- Pregnant women with established & gestational diabetes
- Patients with Type 1 diabetes

3.5 Interdependence with other services/providers

Commissioners of diabetic services are committed to ensuring that structured education is an integral part of the diabetes care pathway. Education is an integral part of the treatment and not an add-on to regular services.

The Provider will be expected to work with and in conjunction with other health professionals

regarding patients diabetic care; this includes:

- General Practitioners
- Secondary Care Providers
- Social care providers and commissioners
- Education providers
- Community health providers
- CAMHS
- Acute Providers
- Housing
- Youth Offending Services/Forensic Services
- Learning Disability Services
- Voluntary/Third Sector
- NHS Continuing Care Assessment Services

4. Applicable Service Standards

4.1 Applicable National Standards

- NICE NG17 – Type 1 Diabetes in Adults: Diagnosis and Management July 2016
- NICE NG28 – Type 1 Diabetes in Adults: Management May 2017
- NICE QS6 – Diabetes in Adults Quality Standard
- other guidance relevant to structured education, including (PH35) [Type 2 diabetes prevention: population and community-level interventions](#) ; (PH46) [BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups](#)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

N/A

4.3 Any other relevant or applicable standards

5. Applicable quality requirements and CQUIN goals

See Schedule 4 and 3.

6. Location of Provider Premises

Offered at a number of locations throughout the East Staffordshire locality: on variable working day week during the hours of 9am-4:30pm

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	DSE_01
Service	Diabetes Structured Education
Commissioner Lead	Sharon Cooper, Commissioning Manager
Provider Lead	TBC
Period	1 April 2022 to 31 March 2023
Date of Review	Upon Commissioner or Provider request

1. Population Needs

1.1 National context and evidence base

Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year¹; the number of people in the UK with diabetes is also increasing and is projected to rise from 3.1m to 3.8m by 2020².

Coinciding with the increasing obesity levels in the UK it is expected that the incidence of Type 2 Diabetes (which accounts for approximately 90% of diabetes in the UK³) will increase; as a result of this it is estimated the number of people with diabetes in the UK will rise to 4.6m by 2030⁴. This makes it the long term condition with the fastest rising rate of prevalence⁴.

Based on estimates from Diabetes UK the current cost to the NHS as a result of diabetes is currently £205m, predicted to increase to £252m and £328m by 2020 and 2030 respectively. Around 80% of these costs are due to complications (e.g. inpatient days).

One in 20 people with diabetes also incurs social care costs due to complications such as heart disease, stroke, blindness, kidney disease and amputations, with 75% of these resulting in residential and nursing care and the remaining being community based. Estimates from Diabetes UK suggest that the total cost of caring for people with diabetes in adult social care settings in Staffordshire and Stoke-on-Trent is £17m per year, predicted to rise to £21m and £27m by 2020 and 2030 respectively. Research also indicates that around one in four people living in care homes have diabetes.

Diagnosed diabetes prevalence in both Staffordshire and Stoke-on-Trent has increased from 5.9% (43,700 cases) in 2006/07 to 7% in 2014/15 (64,600 cases).

In November 2015 the Staffordshire Health and Wellbeing Intelligence group produced a report on Diabetes Prevention. This report indicates that with improvements in awareness, early diagnosis and recording; and the current obesity trend; the prevalence of Diabetes across Stoke-on-Trent and Staffordshire will continue to increase and will be 8.7% by 2020 and 11.3% by 2030⁵

The current prevalence rate in England for diabetes is 6.5%; as indicated in the figures below both North Staffs and Stoke on Trent CCG's are significantly above the national average. It should also be noted that this does not take account of the many people who remain undiagnosed and therefore these figures could be potentially be much higher.

Diabetes: Quality and Outcomes Framework (QOF) prevalence (aged 17+) 2015/16

North Staffs CCG: 7.38%

Stoke on Trent CCG: 7.83%

England: 6.5%

Optimising control of blood glucose levels and blood pressure can reduce the impact of complications significantly. Better blood glucose control reduces the risk of major diabetic eye disease by a quarter and early kidney damage by a third.

The necessary lifestyle changes, the complexities of management and the side effects of therapy make education for people with diabetes a central part of diabetes management. Diabetes usually falls into the following categories; however there are other less common forms including for example MODY, LADA (this list is not exhaustive):

Type 1 diabetes (T1DM) develops if the body cannot produce any insulin. It usually appears before the age of 40 years, especially in childhood. It is the less common of the two types of diabetes. It cannot be prevented and it is not known why exactly it develops. Type 1 diabetes is treated by daily insulin doses by injections or via an insulin pump.

Type 2 diabetes (T2DM) develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). Type 2 diabetes is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin can be required.

Ten per cent of people with diabetes have T1DM, and 90 per cent have T2DM

Structured education and self-management programmes aim to improve outcomes by:

- Stressing the importance of acceptance of diabetes and addressing the person's health beliefs;
- optimising their metabolic control;
- addressing their cardiovascular risk factors (helping to reduce the risk of complications);
- helping them to change their behaviour (such as increasing their physical activity);
- improving their quality of life and reducing any depression.

Patient centred care is key for people with Diabetes. Self-care can be a complex issue, and it is vital that people with diabetes have the skills they need to manage their condition effectively. This highlights the need for patient education to be a key part of any local diabetes service.

References

1. National Diabetes Audit Mortality Analysis 2007-2008 – NHS Information Centre, 2011
2. The management of adult diabetes services in the NHS - National Audit Office; 2012 in POSTNote Number 415 Preventing Diabetes, July 2012
3. Diabetes in the UK 2012: Key statistics on diabetes, Diabetes UK, 2012
4. Commissioning Excellent Diabetes Care: an at a glance guide to the NHS Diabetes Commissioning Resource – NHS Diabetes and Diabetes UK, February 2012, Second edition
5. Staffordshire and Stoke-on-Trent Focus on Healthy Lifestyles – Diabetes Prevention, Staffordshire Observatory November 2015

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	✓

2.2 Local Defined Outcomes

- Improve patient knowledge, health beliefs, and lifestyle changes to enable them to self-manage their condition through:
 - Improved glycaemic control
 - Reduced BMI, cholesterol & blood pressure
 - Increased levels of physical activity
 - Increased smoking cessation rates
 - Lower levels of depression
- Increase participant's self-efficiency, increase motivation and attitudes to self-care thereby reducing complications / crisis management and unplanned use of secondary care health services.
- Reduce the need for, and potentially better targeting of, medication and other items, for example blood testing strips.
- Reduce inequalities and improved access to educational support, especially among black and minority populations.
- Increased patient choice and improving partnership working, patient experience and engagement.
- Increased cost effectiveness of services.
- Reduction in visits to General Practices and missed appointments.
- Patients are able to set their own goals and develop their own personal action plan regarding future diabetic management.

3. Scope

3.1 Aims and objectives of service

Provide an accredited programme of diabetes education for all adult patients diagnosed with diabetes within the North Staffs / Stoke on Trent CCG area to support them in the effective self-management of their condition. Programmes should be delivered by appropriately trained educators, be evidence based and suit the needs of the individual. Programmes should have specific aims and learning objectives to support individuals plus family/carers enabling them to take increasing control of their own condition and integrate effective self-management into their daily lives.

High-quality structured education can have a profound effect on biomedical outcomes, and can significantly improve quality of life and satisfaction for patients with diabetes.

This service shall:

- Deliver standardised high quality, evidence based structured education for all adults who have diabetes within North Staffordshire and Stoke on Trent CCG's that is consistent with NICE and all national/local standards and guidance on how the programmes are delivered and suits the need of the person.
- Improve the quality of life for people newly diagnosed with diabetes enabling them to develop the necessary skills and knowledge to manage their condition.
- Have specific aims and learning objectives, supporting the person and their family members and carers in developing attitudes, beliefs, knowledge and skills to self-manage diabetes.
- Have a structured curriculum that is theory-driven, evidence-based and resource-effective, has supporting materials, and is written down.
- Be delivered by trained educators who have an understanding of educational theory appropriate to the age and needs of the person, and who are trained and competent to deliver the principles and content of the programme. All members of the healthcare team must be familiar with the content of local education programmes, to ensure that consistent advice is given to all patients.
- Be quality assured, and reviewed by trained, competent, independent assessors who measure it against criteria that ensure consistency.
- Regularly audit the outcomes.
- Empower adults with diabetes to manage their condition by supporting the development of self-management/self-care skills to reduce the risk of people with diabetes developing complications.

- Have mechanisms in place to maximise attendance at each education session and reduce the overall number of non-attenders and dropout rates.
- Provide psychological support for adults diagnosed with diabetes aimed at improving mental wellbeing by supporting the development of self-management / self-care skills and where required refer on to the Diabetes and Emotional Wellbeing service.

3.2 Service descriptions/care pathway

There are two broad categories of structured education programmes:

- 1) Structured Education for patients diagnosed with T1DM.
The majority of these patients will be under the care of a secondary care consultant and/or being cared for under a shared care agreement with primary care.
- 2) Structured Education for patients diagnosed with T2DM
The majority of these patients will be under the care of primary care.

The service shall deliver accredited structured education sessions in accordance with current national guidance to meet the requirements of patients diagnosed with **both** T1DM and T2DM and be offered to 100% of all adults newly diagnosed.

The Structured Education Programmes shall will satisfy the following criteria:

- Have a person centred, structured curriculum that is theory driven and evidence based, resource effective and efficient, has supporting materials and is written down.
- Be responsive to the needs of service users and carers, and provide equitable access, ensuring that service users are treated with dignity and respect, are fully informed about their diabetes management and are able to make decisions about their diabetes management in partnership with healthcare professionals.
- Be flexible to suit the needs of the individual (for example including the assessment of individual learning needs) and to cope with diversity, for example meeting the cultural, linguistic, cognitive and literacy needs in the locality.
- Offer group education as the preferred option, but with an alternative of equal standard for a person unable or unwilling to participate in group education.
- Enable people with diabetes and their carers to contribute to the design and provision of local programmes.
- The programme shall help people with diabetes, and their carers to improve knowledge of diabetes and understand the aims of its management to prevent complications.
- Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, cultural or language barriers. The Provider should make adequate and reasonable provision for interpreters, carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.

The Provider is expected to offer flexibility with regard to days and times sessions are held (e.g. extended hours and weekends) to reflect peoples' commitments and encourage maximum levels of attendance; this shall be suitable for the different demographics of the population taking into account bus routes, parking and disabled access etc.

Bite-Size Sessions

To support the structured education sessions for patients with T2DM the Provider will also offer bite-size 'introductory' one hour sessions of the accredited course covering a range of topics. These sessions shall be at accessible locations and offered at a variety of times and venues to increase self-care and management of diabetes in patients and lead to greater take up of the full day accredited structured

education course.

Referral Route

Referrals will be accepted via paper and Choose and Book from the following Health Professionals:

- GP
- Advance Nurse Practitioner
- Practice Nurse
- Tier 3 Community Specialist Team
- Case Manager
- Secondary Care
- Self-referral

For self-referral the Provider shall ensure that there is access and clear advertising to enable patients wishing to participate in structured education to easily book a place on a course.

Service Response Times

Patients diagnosed with diabetes will be offered an appropriate accredited structured education programme as soon as possible after diagnosis. The Provider shall ensure that all referrals are contacted within 2 weeks of the referral to discuss the options and agree the most appropriate programme for the individual. All patients shall be offered a place in an education programme within 4 weeks of referral.

For patients with T2DM all education should have been completed within 12 weeks of diagnosis and patients with T1DM the education programme should commence within 6-12mths after diagnosis; with the exception of pre-existing patients who have not previously undertaken education.

Confirmation of the booking should be issued to all patients within 5 days of the booking.

Providers shall establish protocols for patients that have not responded and subsequently booked a place on a course. Providers shall also issue reminders to patients during the week of the booked course to ensure maximum attendance (e.g. text alerts).

Did Not Attend (DNAs)

The Provider will be responsible for following up any patient that does not attend a scheduled education session to establish the reasons for this and to offer an appropriate alternative. GPs must be informed in writing of any DNA's and the failure of any patient to complete an education session.

3.3 Population covered

The service will be available to all adults registered with a general practice in North Staffordshire or Stoke on Trent CCGs.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

- All patients over 18 years of age
- Newly diagnosed diabetics with Type 1 or Type 2 diabetes within 9mths of diagnosis
- All pre-existing patients with Type 1 or Type 2 diabetes who have not previously partaken in structured education.
- Patients diagnosed with less common forms of diabetes including MODY, LADA (this list is not exhaustive)
- People with poorly managed pre-existing diabetes - IFCC \geq 86.

Exclusion criteria

- Adults living outside of North Staffs or Stoke on Trent CCGs who are not registered with a local GP

- Children & adolescents
- Severe & acute complications related to their diabetes
- Pregnant women with established & gestational diabetes

3.5 Interdependence with other services/providers

Commissioners of diabetic services are committed to ensuring that structured education is an integral part of the diabetes care pathway. Education is an integral part of the treatment and not an add-on to regular services.

The Provider will be expected to work with and in conjunction with other health professionals regarding patients diabetic care; this includes:

- General Practice
- University Hospital North Staffordshire
- Staffordshire & Stoke on Trent Partnership Trust
- Commissioners
- Public Health
- Community Nurses
- Medicines Management
- Community Pharmacists
- Patients & Carers
- Patient & Participation Leads
- Local Diabetes Support Groups

The Diabetes Structured Education programme will link into the Diabetes Network.

4. Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

When providing services to NHS patients, providers shall, at all times operate in accordance with the law, good clinical practice and good health or social care practice, including relevant NICE guidelines and guidelines from the Royal Colleges.

- NICE NG17 – Type 1 Diabetes in Adults: Diagnosis and Management July 2016
- NICE NG28 – Type 1 Diabetes in Adults: Management May 2017
- NICE QS6 – Diabetes in Adults Quality Standard
- other guidance relevant to structured education, including (PH35) Type 2 diabetes prevention: population and community-level interventions ; (PH46) BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups

4.2 Applicable Standards Set Out in Guidance and/or Issued by a Competent Body (e.g. Royal Colleges)

Not Applicable

4.3 Applicable Local Standards

5. Applicable Quality Requirements and CQUIN Goals

a. Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN Goals (Not Applicable, CQUIN Value inclusive Costs and EACV)

6. Location of Provider Premises
The provider shall operate out of a range of premises for easy access for the Localities
7. Individual Service User Placement
Not applicable.

Service Specification No.	ESCS_04
Service	Nutrition Support Service (Dietetics)
Commissioner Lead	Lee Squire, Associate Director, Provider Management
Provider Lead	Steve Foster – Managing Director
Period	1st April 2023 to 30th September 2023
Date of Review	31st March 2023

1. Locally Defined Outcomes
<ul style="list-style-type: none"> • Patients unable to attend an out-patient clinic due to their health needs receive a high quality safe and accessible nutrition support service • People at high risk of malnutrition are able to manage their weight by the service offering high quality, evidence-based assessment, intervention, education, information and advice • Patients are encouraged to take ownership of their nutrition and self-manage their health and wellbeing wherever possible. • Patients at high risk of malnutrition are supported to self-manage their weight through a ‘food first’ approach and oral nutritional supplements • Unplanned hospital admissions are reduced
2. Scope
<p>2.1 Aims and objectives of service</p> <p>Aims:</p> <ul style="list-style-type: none"> • To provide a high quality, safe, accessible service to people 18 years of age and over identified as being at high risk of malnutrition and are unable to attend an out-patient clinic due to their health needs. • To deliver specialist care in the person’s usual place of residence. • To work collaboratively with other providers, as appropriate, to enable smooth and timely access to and transition between services. • To promote a person-centred approach, placing the patient at the heart of decisions about their treatment; respecting their autonomy, choice and values. • To encourage patients to take ownership of their nutrition and self-manage their health and wellbeing wherever possible. • To develop and improve the service by engaging with and listening to patients, using innovative and flexible approaches. • To provide an efficient and effective service that makes best use of resources. <p>Objectives:</p> <ul style="list-style-type: none"> • To deliver a community-based specialist nutrition support service to people at high risk of malnutrition to manage their weight by offering high quality, evidence based assessment, intervention, education, information and advice, where possible achieving stability or weight gain. • To support people at high risk of malnutrition to self-manage their weight as far as possible through a “Food First” approach and oral nutritional supplements if indicated. • To support patients and their carers towards improved oral intake, enjoyment of food, overall health and wellbeing and quality of life. • To reduce unplanned hospital admissions, GP and hospital appointments for people referred to the service who are at high risk of malnutrition. • To audit and evaluate clinical practice and service delivery, to ensure appropriate use of resources and identify areas for potential improvements.

2.2 Service description

- The primary aim of this community based service is to stabilise or increase the weight of housebound patients referred to the service identified as being at high risk of malnutrition with a MUST score of 3 or more by adopting a "Food First" approach, advising on food fortification, prescription of oral nutritional supplements, lifestyle and onward referral in relation to oral intake.

2.3 Population Needs/Population covered

The Nutrition support service is led by a Specialist Dietician and serves people who are 18 years and over and who are registered with a GP practice in East Staffordshire. (See exclusion criteria below for more detail)

2.4 Any acceptance and exclusion criteria

Acceptance Criteria:

- Adults aged 18 years and over
- Registered with an East Staffordshire GP (other than those listed in exclusion below)
- Unable to attend a clinic due to health conditions
- MUST score of 3 or above
- MUST score of 2 following food fortification and oral nutritional supplements for 8 weeks with no improvement
- Must score of 2 with oral nutritional supplements as sole source of nutrition

Exclusion Criteria:

- Must Score of 2 – where Food First approach and oral nutritional supplements not trialled
- Patients able to attend out-patient clinics
- Patients who are at end of life and dietetic intervention would be deemed detrimental
- Registered with the following practices in East Staffordshire - Balance Street, Northgate, Mill View and Abbots Bromley

3. Applicable Service Standards

- Relevant NICE Guidance
- Relevant National Service Frameworks
- HCPC standards
- BDA standards
- Best Practice Guidance from specialist regional and national groups

4. Applicable quality requirements

See schedules 4 and 6.

5. Boundaries & Operational Needs

5.1: Geographic coverage/boundaries

Patients registered with a GP in East Staffordshire not including practices in Uttoxeter, Rocester and Abbots Bromley

5.2: Location(s) of Service Delivery

The service is provided across the following sites:

- Patients own homes
- Residential homes
- Nursing Homes

5.3 Days/Hours of Operation

Office hours are 8:00am - 4.00pm, Monday-Wednesday.

Appointments are not available at weekends or on Bank Holidays.

5.4 Referral Route

Sources of Referral:

1. GPs
2. Health and Social Care professionals
3. 24 hour care

5.5 Referral Access

This service operates Monday to Wednesday and as it operates with a single dietician there is no service when the Dietitian is absent

5.6 Discharge Criteria

Patients are discharged from the service when any of the following are the case:

- Weight has stabilised or increased and maintained
- Care is transferred to another service
- The patient has not engaged in therapy and/or demonstrated poor attendance in line with the non-attendance policy
- At patient request
- Re-located and registered with a GP out of area.
- Progressed to end of life and continued intervention is contra-indicated.

6. Key performance indicators

See schedules 4 and 6.

Service Specification No.	ESCS_12
Service	Stroke Rehabilitation Service
Commissioner Lead	Lee Squire, Associate Director, Provider Management
Provider Lead	Steve Foster – Managing Director
Period	1st April 2023 to 30th September 2023
Date of Review	31st March 2023

1. Locally Defined Outcomes
<ul style="list-style-type: none"> • Patients with a new diagnosis of stroke are enabled to have early specialist stroke intervention within their normal home environment • High quality and safe specialist stroke intervention and support is provided • The health, well-being and independence of service users is maximised • Users of the service are empowered to take ownership of their condition and to self-manage where possible
2. Scope
<p>2.1 Aims and objectives of service</p> <p>Aims</p> <ul style="list-style-type: none"> • Enable patients with a new diagnosis of stroke to have early specialist stroke intervention within their normal home environment • To provide the highest quality safe specialist stroke intervention and support • To maximise health, well-being, independence and choice for all patients • To deliver intervention in the most appropriate setting ensuring that the person is seen by the right health care professional • Promote person centred care and support ensuring that patients are respected as autonomous individuals and empowered to take ownership of their condition and self-manage where possible • To develop and improve our services by engaging with and listening to patients and their carers, using innovative and flexible approaches • To provide an efficient and effective service that makes best use of available resources • To deliver a service that offers patients dignity and respect • To acknowledge and respect individuality and ensure confidentiality <p>Objectives</p> <ul style="list-style-type: none"> • To ensure that people who experience a stroke and are seen by the service are at the centre of decisions about their treatment • To provide assessment, treatment, education, advice and support to improve quality of life and encourage self-management for patients following a stroke within a community setting through improving mobility and function, increasing activity levels and meaningful occupation, community engagement and social prescribing • To appropriately signpost people to other services as required • To enable people to remain in their own homes/preferred place of care for as long as possible • To prevent avoidable hospital admission and facilitate timely discharge • To work collaboratively with other services to improve patient outcomes • To assist in the evaluation of the service and participate in the redesign of services in response to clinical guidelines <p>2.2 Service description</p> <p>The principle functions of the service are:</p>

- Provision of a specialist stroke assessment, intervention and review according to presenting needs (e.g. by a Physiotherapist, Occupational Therapist, Nurse)
- Provision of a multi-disciplinary team approach as appropriate
- Provision of a range of physical, functional and cognitive intervention as required
- Provision of specialist prevention and self-management advice

2.3 Population Needs/Population covered

This service is provided to people 18 years of age and over who are registered with an East Staffordshire GP and who have a new confirmed diagnosis of a stroke.

2.4 Any acceptance and exclusion criteria

Acceptance Criteria

- 18 years of age or above
- Registered with an East Staffordshire GP
- Confirmed diagnosis of a new Stroke
- Medically stable for discharge home and able to be managed in a primary care setting.
- The Patient has been provided with appropriate communication support or information to enable them to give informed consent to ongoing stroke intervention.
- Feeding / Nutrition and medication needs are managed

Exclusion Criteria

Referrals will not be accepted for:

- Patients in 24 hour care
- Patients in prison
- Patients not meeting the acceptance criteria above
- Ongoing spasticity management including treatment post Botox when not otherwise known to the service

3. Applicable Service Standards

- Relevant NICE Guidance
- Relevant National Service Frameworks
- HCPC standards
- CSP standards
- NMC standards
- RCOT standards
- Best Practice Guidance from specialist regional and national groups

4. Applicable quality requirements

See schedules 4 and 6.

5. Boundaries & Operational Needs

5.1: Geographic coverage/boundaries

Registered population of East Staffordshire

5.2: Location(s) of Service Delivery

The service is provided in the most appropriate location for the patient across the following sites:

- Patient's own homes
- Health centres and clinics

- Local community and community facilities
- Work place

5.3: Days/Hours of operation

The service is provided from Monday – Friday 08.00-16.00.

Appointments are not available at weekends or on Bank Holidays.

5.4: Referral Route

Written and electronic referrals for the service will be received and processed by the Care Co-ordination Centre and will be triaged by the Stroke team. The Care Coordination Centre responds within 24 hours of referral and clinical triage takes place on the same day.

5.5: Sources of Referral

1. Hospital and clinic based Health Professionals
2. GPs
3. Health and Social Care Professionals in the Community

5.6 Discharge Criteria

Patients are discharged from the service when any of the following criteria are met:

- Patient and clinician agreed goals are met and/or reached their optimal function
- The patient is assessed to be competent to self-manage their ongoing rehabilitation/needs/condition without the need for the specialist stroke service
- Care is transferred to another service including secondary care
- At patient request
- Consistent poor engagement with assessment and intervention including non-attendance in line with the policy
- Moved out of area and no longer registered with an East Staffs GP

6. Key performance indicators

See schedules 4 and 6.

Service Specification No.	ESCS_14
Service	Adult Enteral Feeding East Staffordshire
Commissioner Lead	Lee Squire, Associate Director, Provider Management
Provider Lead	Steve Foster – Managing Director
Period	1st April 2023 to 30th September 2023
Date of Review	31st March 2023

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p>Enteral feeding' is a means of delivering nutrition into the gastrointestinal tract through a tube, either via the nose or directly into the stomach or small intestine through a stoma in the intestinal wall. This method of feeding is only necessary/desirable when a patient's nutritional needs cannot be met orally, for various possible reasons. The decision to feed enterally is made by a multidisciplinary team in consultation with the client and his/her family, if possible. Enteral feeding is most commonly used to place feed into a patient's stomach. When necessary it is possible to feed directly into the duodenum or jejunum (small intestine). The route and type of appliance used will depend on the individual circumstances of the patient.</p> <p>The largest group of adults receiving enteral nutrition is due to cancer at 46% of the population with conditions of the central nervous system following at 40% and non-malignant gastrointestinal disorders 9% and other conditions at 5%. The main reason patients commence on enteral nutrition is due to swallowing difficulties and malnutrition to improve nutritional status. The majority of adults receiving enteral nutrition are over 60 years of age making up 65.7% of this population. National data suggest that 12% of this population are able to return to oral nutrition and have the tube removed.</p>
2. Local defined outcomes
See schedules 4 and 6.
3. Scope
<p>3.1 Aims and objectives of service</p> <p>Aims</p> <p>To provide a community-based nutrition and dietetic service for adults registered with a GP in East Staffordshire who are receiving total or supplementary enteral feeding at home i.e. nasogastric, gastrostomy, jejunostomy feeding.</p> <p>Objectives</p> <ul style="list-style-type: none"> • To provide nutrition and dietetic assessment, review and support for adults who are being fed by an enteral feeding tube in a variety of settings, including patients own home, outpatient clinics, and care homes. • To organise the delivery of feeds and ancillaries using locally agreed protocols with the commissioned home enteral feeding provider, GP and pharmacies for patients managed by the dietetic team and those that are funding only patients i.e. those patients being managed by specialist centres. • To provide enteral feeding knowledge and skills to patients/carers and care providers involved in the care of an adult being fed via a feeding tube. • To work with service users and carers to develop individual feeding regimens/treatment plans to meet the nutritional needs of the individuals. • To work as part of multidisciplinary teams to deliver integrated care.

3.2 Service description/care pathway

General Overview

The Adult Specialist Dietetic Service provides the Enteral Feeding Service for adults in East Staffordshire who are receiving all or part of their nutritional requirements via an enteral feeding tube.

Healthcare professionals with relevant skills and competencies will review the indications, route, risks, benefits and goals of nutrition support at regular intervals. The dietitian assesses individual nutrition and fluid requirements and develops a personalised feeding regimen. This intervention is provided at various locations including patients own home, outpatient clinics, and care homes. The dietitians are supported by a dietetic assistant, dietetic assistant practitioners with the registration of new patients, ordering of equipment and updating e-registration systems, processing and receipting invoices from the home enteral feeding commissioned pharmaceutical providers.

Access

Referrals are received from the discharging dietitian within an acute hospital setting to the Community Specialist Dietetic Team.

Days/Hours of operation

Monday – Friday: 08.30 to 16.30 throughout the year excluding bank holidays. (52-week service)

Referral via an answer machine: - 0300 124 0355

Note: messages left after 16.00 will be actioned the next working day.

Frequency of Review

The Dietitian will visit all people discharged into the community with an enteral feed at home, within 2 weeks of discharge. They will then be reviewed on a regular basis according to need until stable. Once stable the Dietitian will maintain contact with the patient, carer or care home, as needed.

The team will develop an individual plan of care with the patient and the care plan will be shared with the individual's GP and with any other professionals involved in care (subject to consent)

Direct Patient care includes

- Regular review / monitoring of patients' nutritional status.
- Telephone reviews, trouble shooting, patient/carer enquiries,
- Review of feeding regimens and making appropriate adjustments
- Review of PEG sites/feeding tube and equipment

Indirect contacts

- Setting patients up on appropriate home delivery systems
- Attending case conferences/ MDT meetings
- Telephone calls to other Professionals/ Agencies
- Report writing
- Patient/User satisfaction surveys
- Training/Updates
- Policy Development
- Development of enteral feeding guidelines and regular reviews and updates where needed.

Care Planning and Coordination

All patients managed by the team will have a care plan developed and agreed with the service user and/or carer.

Discharge Criteria

Patients are discharged from the service when: -

- They no longer require enteral feeding i.e. patients are able to meet their nutritional and fluid requirements orally. If on-going dietetic monitoring is required, the patient will be referred to an appropriate Dietetic Service.
- Transferred out of area
- Deceased

DNA

In the event of a DNA, the Dietitian responsible for the patient episode will review the patient's health records and make a risk assessment of the medical and social issues apparent. The Dietitian will contact the patient/carer/care home offering a further appointment.

If Safeguarding issues are identified, then the appropriate Safeguarding procedures will be followed.

3.3 Population covered

Adults who are receiving part or all of their nutritional requirements via an enteral feeding tube and are registered with a GP in East Staffordshire.

3.4 Acceptance and exclusion criteria and thresholds

Acceptance Criteria

All adults with a GP in East Staffordshire, who require home enteral tube feeding should be referred to the Specialist Dietetic Service even if their dietetic care is provided by a specialist Centre as they will need to be registered with the locally commissioned Nutrition Company Home Delivery Service e.g. Abbott Hospital to Home.

Exclusion Criteria

- Self-referrals.
- Patients who are not registered with a GP in East Staffordshire.
- Patients are not receiving/do not require home enteral feeding.
- Patients who are in hospital

3.5 Interdependence with other services/providers

.Key Relationships are:

- Client and/or their carers
- Community Nursing Teams
- Social Services
- Voluntary Agencies
- GPs and Consultants
- Other Allied Health Professional Services, e.g. Dietitians, Speech and Language Therapists.
- Care homes
- Day services
- Care Agencies
- With provider of home care nutritional deliveries
- Acute Trusts

4. Applicable Service Standards

4.1 Applicable national standards

- NICE – Clinical Guideline 32 Nutrition Support in Adults – Oral Nutrition, support enteral tube feeding and parenteral nutrition.CG32
- NICE – Infection Control; prevention of healthcare-associated infection in primary and community care. cg139
- Relevant National Patient Safety Alerts
- CQC Outcomes Framework

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- British Dietetic Association – relevant position papers/guidelines

- BAPEN (British Association for Parenteral and Enteral Nutrition) – relevant guidelines
- Staffordshire Nutrition Support Guidelines

4.3 Any other relevant or applicable standards.

5. Applicable quality requirements and CQUIN goals

See schedules 4 and 6.

6. Location of Provider Premises

The Provider's Premises are located at:

Adult Enteral feed address: Specialist Adult Dietetic Service

Stonydelph Health Centre

Ellerbeck

Tamworth, B77 4JA

Days/Hours of operation

Monday – Friday 08:30 to 16:30, 52 weeks excluding bank holidays

Telephone: 0300 124 0355 (answer machine)

Note: messages left after 16:00 will be actioned the next working day

7. Individual Service User Placement

N/A

Service Specification No.	ESCS_21
Service	Paediatric Enteral Feeding
Commissioner Lead	Lee Squire, Associate Director, Provider Management
Provider Lead	Steve Foster – Managing Director
Period	1st April 2023 to 30th September 2023
Date of Review	31st March 2023

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p>Enteral feeding' is a means of delivering nutrition into the gastrointestinal tract through a tube, either via the nose or directly into the stomach or small intestine through a stoma in the intestinal wall. This method of feeding is only necessary/desirable when a patient's nutritional needs cannot be met orally, for various possible reasons. The decision to feed enterally is made by a multidisciplinary team in consultation with the client and his/her family, if possible. Enteral feeding is most commonly used to place feed into a patient's stomach. When necessary it is possible to feed directly into the duodenum or jejunum (small intestine). The route and type of appliance used will depend on the individual circumstances of the patient.</p> <p>In children with neurodevelopmental delay, awareness of the health and psychosocial benefits of nutritional support increases the number of children receiving enteral feeding year on year. National data shows this increase to be 5-7%, and children with neurodevelopmental delay form the largest group of children who require enteral feeding. (British Artificial Nutrition Survey data, 2010).</p>
2. Local defined outcomes
See schedules 4 and 6.
3. Scope
<p>3.1 Aims and objectives of service</p> <p>Aims</p> <p>To provide a community-based nutrition and dietetic service for children registered with a GP in East Staffordshire who are receiving total or supplementary enteral feeding at home i.e. nasogastric, gastrostomy, jejunostomy feeding.</p> <p>Objectives</p> <ul style="list-style-type: none"> To provide nutrition and dietetic assessment, review and support for children who are being fed by an enteral feeding tube in a variety of settings, including patients own home, outpatient clinics, and <i>care homes, nurseries/special needs schools</i> To organise the delivery of feeds and ancillaries using locally agreed protocols with the commissioned home enteral feeding provider, GP and pharmacies for patients managed by the dietetic team and those that are funding only patients i.e. those patients being managed by specialist centres. To provide enteral feeding knowledge and skills to patients/carers and care providers involved in the care of a child being fed via a feeding tube.

- To work with service users and carers to develop individual feeding regimens/treatment plans to meet the nutritional needs of the individuals.
- To work as part of multidisciplinary teams to deliver integrated care.

3.2 Service description/care pathway

General Overview

The Paediatric Dietetic team provides a service to children (0-18 years, 19 for children attending special schools) and their families with a wide range of special dietary needs in the community across South Staffordshire. Paediatric Dietitians use the most up-to-date research on food and nutrition in health and disease and translate this into practical and understandable dietary treatment for clients and families to follow on a day to day basis. This includes children struggling to gain weight, allergic to foods or needing to be fed artificially.

The Paediatric Dietitians provide a specialist dietetic service to infants and children with a wide range of medical conditions, some examples are listed below:

- Type 1 and Type 2 Diabetes
- Single and multiple food allergies
- Gastro-intestinal Disease
- Complex Feeding Difficulties – including children who require home enteral (tube) feeding
- Coeliac Disease
- Autistic Spectrum Disorder with restrictive diet
- Faltering Growth

The Children's Dietetic Service provides the Enteral Feeding Service for children in East Staffordshire who are receiving all or part of their nutritional requirements via an enteral feeding tube.

Healthcare professionals with relevant skills and competencies will review the indications, route, risks, benefits and goals of nutrition support at regular intervals. The dietitian assesses individual nutrition and fluid requirements and develops a personalised feeding regimen. This intervention is provided at various locations including patients own home, outpatient clinics, nurseries and special needs schools. The dietitians are supported by a dietetic assistant, dietetic assistant practitioners with the registration of new patients, ordering of equipment and updating e-registration systems, processing and receipting invoices from the home enteral feeding commissioned pharmaceutical providers.

Access

Referrals are received from the discharging dietitian within an acute hospital setting to the Community Specialist Dietetic Team.

Days/Hours of operation

Monday – Friday: 08.30 to 16.30 throughout the year excluding bank holidays. (52-week service)

Referral via an answer machine: - *number tbc*.

Note: messages left after 16.00 will be actioned the next working day.

Frequency of Review

The Dietitian will visit all people discharged into the community with an enteral feed at home, within 2 weeks of discharge. They will then be reviewed on a regular basis according to need until stable. The time between reviews depends on individual needs dictated by age, growth rate, feed tolerance and diagnosis, taking a patient centred approach to all delivered care.

Once stable the Dietitian will maintain contact with the patient, carer or care home, as needed.

The team will develop an individual plan of care with the patient and the care plan will be shared with the individual's GP and with any other professionals involved in care (subject to consent)

Direct Patient care includes

- Regular review / monitoring of patients' nutritional status.
- Telephone reviews, trouble shooting, patient/carer enquiries,
- Review of feeding regimens and making appropriate adjustments
- Review of PEG sites/feeding tube and equipment

Indirect contacts

- Setting patients up on appropriate home delivery systems
- Attending case conferences/ MDT meetings and liaising with other members of multidisciplinary team as required for any related feeding/medical issues, for example, Speech and Language Therapist, GP, Paediatrician.
- Telephone calls to other Professionals/ Agencies
- Report writing
- Patient/User satisfaction surveys
- Training/Updates
- Policy Development
- Development of enteral feeding guidelines and regular reviews and updates where needed.
- Helping manage transition to adult dietetic service if required.

Care Planning and Coordination

All patients managed by the team will have a care plan developed and agreed with the service user and/or carer.

Discharge Criteria

Patients are discharged from the service when: -

- They no longer require enteral feeding i.e. patients are able to meet their nutritional and fluid requirements orally. If on-going dietetic monitoring is required, the patient will be referred to an appropriate Dietetic Service.
- Children with learning disability transitioning to adult learning disability service
- Transferred out of area
- Deceased

DNA

In the event of a DNA, the Dietitian responsible for the patient episode will review the patient's health records and make a risk assessment of the medical and social issues apparent. The Dietitian will contact the patient/carer/care home offering a further appointment.

If Safeguarding issues are identified, then the appropriate Safeguarding procedures will be followed.

3.3 Population covered

Children who are receiving part or all of their nutritional requirements via an enteral feeding tube and are registered with a GP in East Staffordshire.

3.4 Acceptance and exclusion criteria and thresholds

Acceptance Criteria

All children with a GP in East Staffordshire, who require home enteral tube feeding should be referred to the Paediatric Dietetic Service even if their dietetic care is provided by a specialist Centre as they will need to be registered with the locally commissioned Nutrition Company Home Delivery Service e.g. Abbott Hospital to Home.

Exclusion Criteria

- Self-referrals.
- Patients who are not registered with a GP in East Staffordshire.
- Patients are not receiving/do not require home enteral feeding.
- Patients who are in hospital

3.5 Interdependence with other services/providers

Key Relationships are:

- Client and/or their carers
- Community children's nurses.
- Education staff in mainstream, special schools and pre-school settings.
- Health visitors/school nurses.
- Relevant Early years settings.
- Community Nursing Teams
- Social Services
- Schools
- Voluntary Agencies
- GPs and Consultants
- Other Allied Health Professional Services, e.g. Dietitians, Speech and Language Therapists.
- Care homes
- Day services
- Care Agencies
- Home enteral feeding companies
- Companies producing oral nutritional supplements and infant formula (these are often used in enteral feeding)
- Companies who produce enteral feeding tubes and ancillary equipment
- Local acute hospital providers for adults and children
- Hospices

4. Applicable Service Standards

4.1 Applicable national standards

- GAIN Guidelines for caring for an infant, child, or young person who requires enteral feeding
- NICE – Infection Control; prevention of healthcare-associated infection in primary and community care. cg139
- DOH (2010) Essential Steps to Safe, Clean Care – Enteral Feeding
- Relevant National Patient Safety Alerts including
 - NPSA (2005) Patient Safety Alert NPSA/2005/PSA05 Reducing the harm caused by misplaced Nasogastric feeding tubes
 - NPSA (2010) Rapid Response Report NPSA/2010/RRR010 Early Detection of Complications after Gastrostomy
 - NPSA (2011) Patient Safety Alert NPSA/2011/PSA002: Reducing the harm caused by misplaced Nasogastric feeding tubes in adults, children and infants
 - NPSA (2012) Rapid Response Report NPSA/2012/RRR001: Harm from flushing of Nasogastric tubes before confirmation of placement
 - NPSA (2016) Nasogastric tube misplacement: continuing risk of death and severe harm NHS/PSA/RE/2016/006
- CQC Outcomes Framework

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- British Dietetic Association – relevant position papers/guidelines
- BAPEN (British Association for Parenteral and Enteral Nutrition) – relevant guidelines
- Staffordshire Nutrition Support Guidelines

4.3 Any other relevant or applicable standards

5. Applicable quality requirements and CQUIN goals

See schedules 4 and 6.

6. Location of Provider Premises

The Provider's Premises are located at:

Paed Enteral feed address:
Children's Dietetic Service
Sir Robert Peel Hospital
Plantation Ln, Mile Oak, Tamworth B78 3NG

Days/Hours of operation

Monday – Friday 08:30 to 16:30, 52 weeks excluding bank holidays

Telephone: *TBC* (answer machine)

Note: messages left after 16:00 will be actioned the next working day

7. Individual Service User Placement

N/A

Service Specification No.	F04
Service	Specialist Alcohol Liaison and Complex Needs team (CHAT)
Commissioner Lead	Nicola Bucknall, Commissioning Manager, North Staffordshire and Stoke-on-Trent CCGs
Provider Lead	Lisa Nagington, Senior Service Manager, North Staffordshire Combined Healthcare
Period	1 st January 2022 – March 31 st 2023
Date of Review	As required
1. Population Needs	

1.3 National/local context and evidence base

Alcohol-related harm is a long-standing problem that is placing increasing demands on the NHS. At a time when unprecedented efficiencies need to be made by the NHS and local authorities, preventative action must be taken seriously.

Alcohol is the most common cause for liver disease in England and accounts for over a third of liver disease deaths. The more someone drinks over the lower-risk guideline, the higher their risk of developing liver disease. The UK is one of the few European countries where alcohol consumption has risen in the last 50 years.

There were 1.1 million estimated admissions related to alcohol consumption in 2015/16. This is 4% more than 2014/15. This represents 7.0% of all hospital admissions which is similar to 2014/15 and 2013/14.⁴⁹

In 2017/18 there were 338,000 estimated admissions where the **main reason for admission** to hospital was attributable to alcohol (narrow measure). This is **15% higher** than 2007/08

There were 1.2 million estimated admissions where the **primary reason for hospital admission or a secondary diagnosis was linked to alcohol**, which is 3% higher than 2016/17 (broad measure)³. This represents 7.2% of all hospital admissions. 83% were over the age of 45. When looking at diagnosis **52% of admissions were for CVD, 17% were for mental and behavioural disorders due to alcohol**

In England in 2017, there were 5,843 alcohol-specific deaths. **The number of deaths is 6% higher than 2016 and an increase of 16% on 2007.**

Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and

⁴⁹ Statistics on Alcohol England, May 2017, NHS Digital

need specific treatment. Physical comorbidities are common, including gastrointestinal disorders (in particular liver disease) and neurological and cardiovascular disease. In some people these comorbidities may remit on stopping or reducing alcohol consumption, but many experience long-term consequences of alcohol misuse that may significantly shorten their life.

Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions.

Local context

In Stoke-on-Trent:

- It is estimated that nearly one third (31.7%) of adults (aged 18 and over) were drinking more than 14 units of alcohol per week, compared with 25.7% nationally. Adults were also more likely to binge drink.
- In 2017 over 40% of adults (aged 18 and over) were drinking at levels of increasing or higher risk, which equates to around 80,000 people.
- There were an estimated 3,864 dependent drinkers in Stoke-on-Trent in need of specialist treatment.
- Deaths from alcohol reflect the effects of chronic heavy drinking and are most likely to be found in higher risk drinkers and dependent drinkers. Mortality rates from alcohol-specific causes, chronic liver disease and alcohol-related causes were all significantly higher locally compared with England.

Nearly one quarter of alcohol users who started treatment in Stoke-on-Trent had a dual alcohol/mental health diagnosis, which is slightly higher than the national average of 21%.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	ü
Domain 2	Enhancing quality of life for people with long-term conditions	ü

Domain 3	Helping people to recover from episodes of ill-health or following injury	ü
Domain 4	Ensuring people have a positive experience of care	ü
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	ü

2.2 Local defined outcomes

The fundamental goal of the service is to improve the lives of people affected by alcohol; in so doing, the interventions are expected to contribute to a range of broad strategic outcomes, including:

Public Health outcome framework indicators

- 2.15 Drug and Alcohol treatment completions and drug deaths
- 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
- 2.18 Alcohol-related admissions to hospital
- 4.03 Mortality rate from causes considered preventable
- 4.10 Suicide rate

Adult social care outcomes framework

- Enhancing the quality of life for people with care and support needs
- Ensuring that people have a positive experience of care
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Others

- Improve physical and mental health
- Facilitate timely discharge from hospital and continue detox in the community where clinically safe to do so
- Reducing alcohol related deaths
- Improved Public Protection
- Improved parenting / reduced child neglect and abuse

3. Scope

3.1 Aims and objectives of service

- The aim of the service is to improve the lives of people affected by alcohol, their families and local communities.
- To reduce the risks associated with alcohol and to promote change.
- Maintain people safely in the community and reduce avoidable, frequent and costly attendances to hospital for reasons related to alcohol use.
- To work in partnership with other agencies to improve the health and social welfare of service users frequently using secondary care health services, by offering intensive case management, assertive outreach, fast track access pathways and an enhanced recovery support offer

3.2 Service description/care pathway

General principles

The provider will develop evidence based but innovative interventions that are responsive to changing patterns of alcohol use.

The range and ethos of the Services provided should represent an appropriate balance between harm reduction and more recovery oriented approaches.

Deliver a straight-forward pathway that is easy for people to access and navigate and that clearly demonstrates an achievable alternative to the culture of addiction.

Recognize how alcohol problems not only affect individuals but also impact on their families and communities, providers will enable people to take responsibility for addressing their holistic needs and to build the personal strengths needed to maintain strong and sustainable recoveries from alcohol problems.

Specialist Alcohol Liaison and Complex Needs Team (CHAT)

- Through formal pathways, working relationships and regular joint meetings with the Royal Stoke alcohol liaison nurses, identify appropriate service users for the service. They will typically include:
 - Service users presenting to hospital with alcohol dependency as highlighted by AUDIT screening tools, short AUDIT tool 7+, full AUDIT tool 20+
 - Frequent attenders to A&E for reasons related to alcohol use. Reasons for presentation to A&E may include falls, minor injuries, maxillofacial injuries, upper gastrointestinal haemorrhage, acute intoxication, overdose.
 - General Ward service users with co-existing diabetes, cardiovascular disease, chronic pancreatitis
 - Service users who require planned surgery but need detox / support to reduce their alcohol intake
- Liaise with GPs and case managers within other services (e.g. Edward Myers Unit, Intoxication Observation Unit, Harplands Hospital, Mental health liaison Team, High Volume Users Service) to identify Clients most at risk of relapse or readmission.
- All clients identified as:
 - Frequent attenders to hospital **AND / OR**
 - Having complex multiple physical / mental health needs **OR**
 - Having difficulty engaging with general community addiction services

Will be case managed for a time limited period until the service users risks are minimised / managed (see criteria below). **Step down to other services in the pathway is expected within 3 months but will be determined by need / clinical risk.**

- Provide **rapid access pathways** for community detox supported by wrap around pre-detox (where possible) and enhanced post-detox care.
- Enable safe transfer of care for patients presenting to emergency portals that are suitable for community detox. Provide clinical management of patients over a 7 - 10 day period to ensure safe withdrawal of alcohol. **Patients referred from ED must receive a face to face contact within 24 hours.**

- Similarly there may be people in the community either identified by GPs or by community services that are **attempting to detox themselves and are at risk of dangerously withdrawing** this may require immediate support from CHAT to reduce risk of hospitalisation. The person should be assertively managed and engaged in wider community services before discharge from the CHAT service.
- Provide assertive outreach to clients on the caseload to maintain engagement in services in the community.
- The service should be innovative for particularly hard to reach groups (e.g. homeless) and make reasonable adaptations, whilst maintaining safety, to meet the needs of the person. Links with local hostels and charitable organizations should be developed.
- Make every attempt to engage clients in treatment and proactively contact clients in a variety of ways should they DNA
- Use validated screening and outcome tools e.g. FAST, AUDIT, SADQ and CIWA.to determine the most appropriate treatment pathway and evidence impact of interventions
- Deliver brief interventions, extended brief interventions and care planned interventions, supported by co-ordination of care in the community and active review/follow up.
- Facilitate **fast track access** to inpatient detox /rehab beds as clinically indicated
- Clinical monitoring and management of clients undergoing community detox such as:
 - Pulse, blood pressure monitoring
 - Physical examination (particularly respiratory and abdominal)
 - Taking bloods
 - Measure breath alcohol levels
 - Administration of medication
 - Prescribe medication where appropriate and in line with clinical competencies and local protocols Review clients 7 days post detox to check physical symptoms
- Assess clients risk where appropriate for alcohol related brain injury using tools such as Addenbrooks Cognitive examination (ACE) and Montreal Cognitive Assessment (MoCA) and refer to neuropsychiatry where specialist assessment is indicated
- Deliver motivational and psychosocial interventions focusing on a strength based
- Practitioners will also initiate and take part in multidisciplinary team meetings to ensure co-ordinated care, particularly for those clients that are presenting multiple times to A&E and / or IOU

- Introduce Clients to recovery communities and mutual aid.
- Support the service users holistic needs and using a care coordinator approach, facilitate multiagency working across a range of sectors, case manage until risk complexity has reduced / stabilised
- Services must respond (either through direct service provision of engagement in partner services) to more than physical and/or psychological dependence by addressing issues that contributed to the development of alcohol problems (such as trauma or bereavement) as well as helping people develop the skills required to build sustainable recovery.

Fast Track access to treatment

The service will establish a process whereby patients who are frequent users of hospital services or have complex needs that puts them at risk of frequent hospitalisation; will **as part of an urgent care pathway** be given priority access to the range of treatment options offered by the community drug and alcohol service (including access to inpatient detox, rehabilitation, recovery services).

Priority will be based on clinical needs / risks and be determined following an MDT discussion. This will include professionals from other organisations as required.

A standard operating procedure will be developed which describes the process and priority criteria.

Referred cases will be reviewed and allocated on a daily basis for optimum priority risk management.

Staff will carry small caseloads and move patients appropriately through the treatment system so that there is never a waiting list and cases can be seen within agreed timeframes.

- Entry into service - Referrals responded to within 24 hours from any referral source (emergency portals, GP, IOU beds, Ambulance service, hospital wards, either face to face or by telephone
- Cases where detox was completed in hospital will have a home visit within 24 hours of discharge to discuss post detox support options –

- If this support is accepted cases will be managed by support workers who will facilitate appropriate post detox support including psycho social interventions, workshops,, social activities, mutual aid including AA.
- If the offer is declined and support is not accepted cases will be discussed at a weekly management meeting and appropriate next steps agreed
- Patients referred for continued detox will be seen within 24 hours of hospital discharge to enable medically supported early discharge.
- For cases requiring a detox commencement, comprehensive nurse assessment will take place includes physical health assessment, risk assessment, social circumstances assessment, facilitate bloods where appropriate
- Detox commencement will take place within a timeframe agreed with the service user and will be dependent on clinical risks but will commence no later than 48hours from referral
- Home visits will take place for the duration of the detox and service users will will have a post detox 7 day review and then be supported to access post detox support.
- For cases where the physical complexities deem the case to be too high risk for a home detox, referral is made to EMU in patient facility and discussed at the weekly referral meeting for prioritisation.
- MDT will take place weekly for team discussion, risk management, detox update, step up and step down cases. Every new CHAT case is discussed to ensure that every individual is receiving the optimum and appropriate care matched to their needs and to allow for new referrals being received by the team.

Enhanced Recovery

Harm reduction approaches

Harm reduction is a key component of the Services for all applicable service users, but particularly for people drinking heavily and may form part of both structured and open access Services. A number of core Services must be delivered:

- ☐ Self- help and information packs including where to access additional non-alcohol related support in line with asset based community development
- ☐ Education and harm reduction preventative initiatives in line with government safe drinking levels
- ☐ Open access advice/ information (telephone or 1-1)
- ☐ Healthcare assessments and support for health problems
- ☐ Open access support for hard to reach groups (homelessness drop ins)

Providers are also expected to deliver other harm reduction Services, potentially including but not limited to:

- ☐ Brief/ short term interventions
- ☐ Complementary therapies

Proactive re/engagement activities

Proactive Services will be required to identify and engage people (particularly priority groups), A number of engagement activities must be delivered:

- ☐ Liaison with health and social care services (acute/mental health, social services etc.) in order to maintain engagement, including dual diagnosis with physical and mental health problems and promote early supported discharges from acute hospitals, where appropriate
- ☐ Liaison with criminal justice agencies (including (but not limited to) the police, probation, courts and prisons) to ensure that opportunities to engage offenders into specialist Services are maximised and people do not disengage with Services as they move through the criminal justice system, in particular those sentenced to an ATR.
- ☐ Where other priority demands on the service allow, the Providers should have approaches (possibly including outreach initiatives, including working with rough sleepers teams) in place to proactively engage other priority and hard to reach groups

The Providers are strongly encouraged to consider additional approaches and not be limited to these core engagement activities.

Stabilisation/ retention interventions

Structured Services will be required that maintain stability and retain people while identifying needs/ strengths and facilitate behavioural changes. A number of approaches must be delivered:

- Care co-ordination/ case management (varying intensity depending on need/ complexity)
- Fast track step up and step down between; high complexity, medium intensity need
- Support adherence to and facilitate access to pharmacological Services and medications–
- Strength based psycho-social interventions delivered on a 1-1 basis and in workshop formats
- Peer support including mutual aid facilitation/programmes (such as SMART and/or 12-step facilitation)

It is anticipated that the provider will deliver additional Services, possibly including but not limited to:

- ☒ Use of apps
- ☒ Self-help initiatives including work books and mapping exercises

Progressive Services

Services are required that enable people to progressively achieve their goals, reduce problems and increase strengths, these are likely to include:

- ☒ Community detoxification (for alcohol)
- ☒ Abstinence-oriented approaches
- ☒ Education about safe drinking levels

The service will be expected to support service users holistic needs which may include:

- Referral to and engagement with supported housing and emergency provision for homeless
- Social/ diversionary activities including walking groups, art workshops, First Aid courses
- Fast access to IPS (Individual placement support into employment)
- Complementary therapies
- Social isolation reduction initiatives including gardening, art workshops
- Emotional wellbeing programmes and initiatives
- Access to other commissioned health initiatives (e.g. smoking cessation and healthy weight)

Consolidation Services

Services must be provided that help people consolidate progress made in earlier Services (including following achieving initial abstinence and/or discharge from residential rehabilitation), including (without limitation):

- Providers must facilitate the development of safe and sustainable recovery communities, although these communities must be 'owned' and led by their members (AA, SMART recovery)
- Facilitate access to pharmacological interventions (e.g. Acamprosate)

It is anticipated that a range of other Services may be made available to these service users and possibly including:

- ☐ Extended case monitoring
- ☐ Social enterprises; and
- ☐ Volunteering opportunities.

3.3 Population covered

People who are residents of Stoke-on-Trent will be eligible for the services outlined in this specification.

The service will target dependent drinkers with complex needs (see criteria below).

3.4 Any acceptance and exclusion criteria and thresholds

Eligibility criteria

- The eligibility criteria should be inclusive; to ensure people can access the Services at the point of need and allow resources to be targeted in accordance with needs and strengths; those in greatest need will have access to the most enhanced level of Service provision.
- Services are to be provided for adults aged 18
- Service users referred to the specialist alcohol liaison and complex needs team will:
 - Be frequent users (or at high risk) of multiple emergency services i.e. ambulance, A&E, IOU, Harplands, crisis teams – ‘frequent attenders’ **AND**
 - Typically have an AUDIT score of ≥ 20
 - require increased support for co-existing complex physical health needs (e.g. chronic liver disease, end of life) or dual diagnosis and who require a coordinated case management approach
 - require Increased support to remain engaged in services and who require an assertive management approach (e.g. require home visits, greater number of contacts to remain engaged)
- The service will also support people requiring community detox **as part of a ED / hospital discharge pathway** the aim being to either avoid hospital admission or reduce length of stay.
 - Service users with a CIWA score between 10-15 will be considered for community detox

Exclusions for community detox

- Medical red flags such as; trauma or injury, Delirium tremens, Severe vomiting, GI bleed, malnourished, hallucinations, Wernicke's Confusion, jaundice , high risk suicide, seizures

Operating Hours

The CHAT service will operate a 7 day service, Monday – Sunday, 9am – 5pm (operating times will be regularly reviewed and agreed based on local demand data) - new referrals will be accepted over 7 days.

3.5 Interdependence with other services/providers

There are a number of existing specialist alcohol interventions that will operate alongside this Contract. The provider will need to ensure that they have procedures and protocols in place to ensure a smooth referral pathway to other local services.

A summary of these interventions is provided below:

- Recovery champions – there is a peer-led organisation comprised mainly of people who have successfully exited rehabilitation and are now abstinent; they work alongside other existing services and peer mentor groups to promote and provide highly visible examples of positive recovery.
- 12 steps fellowship – there are a considerable number of Alcoholics Anonymous (AA) meetings running each week across the county.
- Medically managed detoxification – there is a hospital-based inpatient drug and alcohol medically managed detoxification services available to Stoke-on-Trent residents – The Edward Myers Unit located in Stoke-on-Trent.
- Intoxication Observation Unit
- Harplands Hospital
- Mental health Liaison Team
- High Volume Users Service

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Provider will need to ensure their Service delivery model adheres, as a minimum, to the guidance and protocols included in the Contract, including (but not limited to):

- Department of Health (2002) Mental Health policy implementation guide. Dual Diagnosis good practice guide.
- HM Government (2013) Working together to safeguard children: a guide to inter-agency working to safeguard children and promote the welfare of children.
- NICE (2012) Hepatitis B and C: ways to promote and offer testing (PH 43).
- NICE (2011) National Clinical Practice Guideline Number 115: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE
- NICE (2011) Alcohol dependence and harmful alcohol use (QS11).
- NICE (2011) Psychosis with co-existing substance misuse (CG 120)
- NICE (2010) Pregnancy and complex social factors (CG 110)
- NICE (2010) Alcohol use disorders: preventing harmful drinking (PH24).
- NICE (2010) Clinical Guideline 100: ALCOHOL USE DISORDERS: DIAGNOSIS AND CLINICAL MANAGEMENT OF ALCOHOL-RELATED PHYSICAL COMPLICATIONS.
- NICE (2008) National Clinical Practice Guideline Number 51: Psycho-social interventions
- NTA (2008) Good practice in harm reduction.
- NTA (2006) Review of the effectiveness of treatment for alcohol problems

In addition, new guidance documents are periodically published and as such the provider is expected to keep abreast of these and implement where necessary following discussion with Commissioners

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- RCGP (2012) Delivering quality care for drug and alcohol users: the roles and competencies for doctors. A guide for commissioners, providers and clinicians.
- Alcohol Concern/ Drugscope (1999) Quality standards for drug and alcohol services.
- British National Formulary (BNF) good prescribing practice guidance.

4.3 Applicable local standards

- Staffordshire Hidden Harm Strategy
- Staffordshire and Stoke-on-Trent Adult Safeguarding Inter-agency Adult Protection Procedures
- Alcohol Treatment Requirements (ATR) policy

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be delivered in people's homes, community / public venues however staff will be based at:

Edward Myers Unit

Harplands Hospital

Hilton Road

Stoke-on-Trent

Staffs

ST4 6RR

Service Specification No.	UHNM7_Cardiac Rehab_Service Spec
Service	Cardiac Rehabilitation
Commissioner Lead	Paul Brown, Chief Finance Officer NHS Staffordshire and Stoke on Trent ICB
Provider Lead	Matt Warrilow, University Hospital North Midlands
Period	1 st April 2023 – 31 st March 2024
Date of Review	31st March 2023

1. Population Needs		
1.1 National/local context and evidence base		
National context		
<p>Cardiac rehabilitation is a structured set of services that enables people with Cardiovascular Disease (CVD) to have the best possible help, physical, psychological and social, to preserve or resume their optimal functioning in society.</p> <p>The World Health Organization has defined cardiac rehabilitation as:</p> <p><i>'the sum of activities required to influence favorably, the underlying cause of the disease, as well as the best possible, physical, mental and social conditions, so that they (people) may, by their own efforts preserve or resume when lost, as normal a place as possible in the community. Rehabilitation cannot be regarded as an isolated form or stage of therapy but must be integrated within secondary prevention services of which it forms only one facet.'</i></p>		
2. Outcomes		
2.1 NHS Outcomes Framework Domains & Indicators		
Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓
2.2 Local defined outcomes		
Priority 1	Better and More: a community focused model of care	
Priority 2	Improved care and outcomes for people with LTCs	✓
Priority 3	Use patient experience to improve quality of care	✓
Priority 4	Deliver 'Must do's'	

Roger Boyle CBE, National Director for Heart Disease, states that there is a wealth of evidence to support the fact that Cardiac Rehabilitation improves outcomes for many people with heart disease, enabling them to remain active for longer and manage their condition more effectively. Cardiac rehabilitation is a cost-effective way to help people with heart disease live longer, healthier lives and that people value it, deriving significant benefit, particularly in terms of improving their quality of life. The NHS has a responsibility to ensure that those who are eligible and can benefit from Cardiac Rehabilitation are able to do so.

The Coronary Heart Disease National Service Framework reported that Cardiac rehabilitation forms an intrinsic part of the cardiac pathway for eligible patients. Cardiac rehabilitation is recommended in NICE clinical guideline 48 on myocardial infarction (MI): secondary prevention as an appropriate intervention for people following a hospital admission.

This supports the National service framework for coronary heart disease which sets the standard that: 'NHS Trusts should put in place agreed protocols/systems of care so that, prior to leaving hospital, people admitted to hospital suffering from coronary heart disease have been invited to participate in a multidisciplinary programme of secondary prevention and cardiac rehabilitation. The aim of the programme will be to reduce their risk of subsequent cardiac problems and to promote their return to a full and normal life'.

There is evidence that exercise-based cardiac rehabilitation:

- Is effective in reducing total and cardiovascular mortality and hospital admissions in people with coronary heart disease
- Reduces all-cause and cardiovascular mortality rates in patients after MI when compared with usual care provided when it includes an exercise component
- Significantly reduces hospitalisation for chronic heart failure and significantly improves quality of life and exercise tolerance for people with heart failure

Cardiac rehabilitation is widely considered the “unfinished business” of the National Service Framework for Coronary Heart Disease (CHD NSF, 2000). Despite the NSF goal of 85% of patients discharged from hospital after a heart attack or revascularisation procedure being offered cardiac rehabilitation, current figures identify that this is far from the case. The National Audit of Cardiac Rehabilitation (published in August 2009) reveals that of the 153,294 people who had a heart attack or had revascularisation in 2007/8, only 38% (51,232) participated in a Cardiac rehabilitation programme. The latest annual report (NACR, 2017) reports uptake for cardiac rehabilitation as being 51% for this group.

There is evidence that cardiac rehabilitation reduces cardiac related morbidity, which in turn reduces readmissions and the need for cardiac follow up consultation. Cardiac rehabilitation also supports patients return to work, improves their functional capacity and physical activity status, perceived quality of life and supports the development of self-management skills. The benefits of a menu driven approach, with a choice of setting and individually identified patient goals are increasingly recognised.

3. Scope

3.1 Aims and Objectives of Service

The overall aim of the cardiac rehabilitation service is to provide all patients who fulfil the referral criteria with a patient led service, which optimises their health and wellbeing, enhances their quality of life and minimises the risk of recurrent cardiac events.

- To ensure the provision of cardiac rehabilitation to facilitate recovery from a range of cardiac events
- To ensure that there is a smooth and consistent referral process into the cardiac rehabilitation process
- To provide a time limited period of comprehensive cardiac rehabilitation which combines an exercise programme with psychological and educational interventions
- To ensure that there is formal and planned discharge from the rehabilitation programme into the community, which should include a plan for the long-term maintenance of physical activity and lifestyle change
- To monitor access and uptake of specific patient groups
- To provide a high-quality service, which will deliver the key service outcomes
- To provide a patient led cardiac rehabilitation service which meets the personal needs of each patient
- To ensure patients and carers have appropriate information allowing them to manage their care more effectively along the pathway
- To engage patients and their carers in decisions about the care options available to them, including the development of individual care plans and long-term management plans
- To promote and facilitate proactive identification, encouragement and referral of eligible patients
- To provide continuity and co-ordination of care across the pathway
- To ensure the service is readily accessible, particularly among the following patient groups
- To ensure the service is delivered in a timely manner

The National service framework for coronary heart disease established a goal that every hospital should ensure that more than 85% of people discharged from hospital with a primary diagnosis of acute MI or after coronary revascularisation are offered cardiac rehabilitation. It is also recommended in NICE clinical guideline 94 on unstable angina and non-ST-segment-elevation MI (NSTEMI). NICE clinical guideline 108 on chronic heart failure published in 2010 makes a new recommendation supporting cardiac rehabilitation for people with stable chronic heart failure without a condition that could preclude exercised based rehabilitation. The Department of Health's Cardiovascular Disease Outcomes Strategy (2013) sets out an ambition to increase the provision of cardiac rehabilitation to 65% of AMI, CABG and PCI patients and increase the provision of cardiac rehabilitation from ~4% to 33% of heart failure patients.

3.2 Service Description/Care Pathway

The Cardiac rehabilitation pathway should be offered as a structured, comprehensive package of support that includes exercise, education and psychological support. The programme should be tailored to the needs of each patient based on a comprehensive assessment of their cardiac risks and individual goals.

Participants should be encouraged to attend all components appropriate to their clinical needs and should not be excluded from the entire programme if they choose not to attend certain components.

Delivery of programme components should be preceded by an initial medical assessment to determine a person's individual needs, goals, medical risk factors and limitations. Assessment should also take place at the end of a programme to review a person's progress and ongoing needs.

Cardiac rehabilitation should be offered as a comprehensive package, including exercise, education and psychological support. It should not be regarded as an isolated form or stage of therapy but be integrated within secondary prevention services. Cardiac rehabilitation services are no longer exclusively hospital based; emphasis is placed on helping patients become active self-managers of their condition. This can involve hospital or community based cardiac rehabilitation programmes. Collaboration between primary and secondary care services is vital in order to achieve the best cardiac rehabilitation outcomes.

The care pathway should be person/patient-centered and integrated with other elements of care for people/patients with cardiovascular disease and other long-term conditions.

Using best practice care pathway stages 0 to 6 to reflect core stages in the cardiac rehabilitation pathway:

- Stage 0 Identify and refer patient
- Stage 1 Manage referral and recruit patient to cardiac rehabilitation programme
- Stage 2 Assess patient for cardiac rehabilitation
- Stage 3 Develop patient care plan
- Stage 4 Deliver comprehensive cardiac rehabilitation programme
- Stage 5 Conduct final assessment
- Stage 6 Discharge and transition to long-term management

3.3 Population Covered

The Cardiac Rehab Service shall provide care to all service users of the Commissioner's population, irrespective of the postcode and must be registered with a Stoke on Trent, North Staffordshire, Stafford & Surrounds or Cannock GP Practice.

3.4 Any Acceptance and Exclusion Criteria and Thresholds

The following conditions have been included for referral to cardiac rehabilitation:

- patients who are myocardial infarction (MI) percutaneous coronary intervention (PCI)
- patients who are coronary artery bypass graft (CABG)
- patients with stable chronic heart failure
- patients with stable angina
- patients with cardiac diagnosis other than the above who have been referred by their physician

This service is accessible to adults only and service users must be registered with a Stoke-on-Trent, North Staffordshire, Stafford & Surrounds or Cannock Chase GP Practice. Children and young people under the age of 18 should be referred directly to the acute trust.

3.5 Interdependence with other services/providers

- Not applicable

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Commissioners should ensure that providers implement the recommendations stipulated in NICE guidance and that providers are taking steps to achieve the standards set out in NICE quality standard for chronic heart failure.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The British Association for Cardiovascular Prevention and Rehabilitation document 'BACPR Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation (2012)' sets out the core components of a cardiac rehabilitation programme as follows:

- health behavior change and education
- lifestyle risk factor management (physical activity and exercise, diet, and smoking cessation)
- psychosocial health
- medical risk factor management
- cardio-protective therapies
- long-term management
- audit and evaluation

4.3 Applicable local standards

All core team members treating and managing patients should be professionally qualified, work within their professional scope of practice and have evidence based professionally verified cardiac rehabilitation education, training and competencies.

All staff providing cardiac rehabilitation programmes are competent to identify anxiety and depression and are able to support people to self-manage or refer them to the right service. See NICE commissioning guide on common mental health disorder services for further information.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

To provide a high-quality service, which will deliver the key service outcomes:

- **actively identifying all people** potentially eligible for cardiac rehabilitation and encouraging them to take part in cardiac rehabilitation
- **improving referral, uptake and completion of cardiac rehabilitation programmes**
- **comprehensive assessment of an individual**, including their need for cardiac rehabilitation
- **developing individualised plans to a person's needs** in line with NICE guidance and the British Association for Cardiovascular Prevention and Rehabilitation document 'BACPR Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation'
- **offering hospital/ community programmes** in line with NICE guidance and evidence-based national programmes
- **providing core components of the programme** in line with the British Association for Cardiovascular Prevention and Rehabilitation document 'BACPR Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation', including exercise, education, risk factor management and social and psychological support
- **providing the best possible outcomes** for individual people/patients, their carers and local communities

- **providing a quality assured service**

The specification shall be jointly reviewed by the Provider and Commissioner from time to time. In no way should this service specification preclude the provider from innovating and/or developing new ways of working.

Schedule 6 – contract management, reporting and information requirement

National Requirements Reported	
Quarterly Cardiac Rehab Dashboard Report (please see Appendix one)	Submit to Co-coordinating Commissioner by 15th operational day a month in arrears of the end of the quarter to which it relates i.e. August, November, February and May

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

Not applicable

6. Location of Provider Premises

The Provider’s Premises are located at:

The Provider’s Premises are located at the Trent Building, Royal Stoke University Hospital. Community facilities for Northern Staffordshire are:

- The Wallace Centre in Abbey Hulton,
- Dimensions Leisure Centre in Tunstall
- Fenton Manor Sports Complex in Fenton,
- Brough Park Leisure Centre in Leek,
- Biddulph Valley Leisure Centre in Biddulph,
- Newcastle-under-Lyme College
- Jubilee 2 in Newcastle-under-Lyme.

Community Facilities for South Staffordshire are:

- Stafford Leisure Centre
- County Therapy Gym
- Westbridge Park Leisure Centre
- Rugeley Leisure Centre

The operating times should be between 09:00 and 16:00, Monday to Friday.

7. Individual Service User Placement

Not Applicable.

8. Activity

12 months indicative activity is:

CCG Code	CCG	Activity
05W	Stoke on Trent CCG	1028
05G	North Staffs CCG	950
05V	Stafford & Surrounds CCG	455
04Y	Cannock CCG	245

9. Price & Costs

Block Contract

