

APPENDIX 2A: SCHEDULE 2 – THE SERVICE Service Specifications

Key:

	Specification accepted
	Specification expired and internal review started
	Specification expired and for development in 2023-24
	Specification expired and no work undertaken to review
	National specification

Ref No.	Service Spec	Geography for service provision	Current Status (see key above)	Specification included
CS_01	Community Specialist Asthma Nurse	Stoke-on-Trent		Y
CS_02	Asylum Seeker & Refugee Health Team	- North Staffordshire - Stoke-on-Trent		Y
CS_03	Children's Community Nursing Team	Pan-Staffordshire & Stoke-on-Trent		Y
CS_04	Community Continence (Adults & Young People)	- North Staffordshire - Stoke-on-Trent		Y
CS_05	Community Occupational Therapy (children's)	Pan-Staffordshire & Stoke-on-Trent		Y
CS_07	Community Adult Occupational Therapy	- North Staffordshire - Stoke-on-Trent		Y
CS_08	Community Adult Speech and Language Therapy	- North Staffordshire - Stoke-on-Trent		Y
CS_09	Youth Offending Service (YOS) Health Provision	Stoke-on-Trent		Y
CS_10	Children and Young People Targeted (Health) Intervention Service	Stoke-on-Trent		Y
CS_11	Home Oxygen Service - Assessment & Review	- Cannock Chase - Stafford & Surrounds		Y
CS_12	Clinical Nurse Specialists in Primary Care – Adults with Learning Disabilities	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_13	Community Fall's Service (SES Locality)	South East Staffordshire & Seisdon Peninsula		Y
CS_14	Community Falls Service (Seisdon Locality)	South East Staffordshire & Seisdon Peninsula		Y

Ref No.	Service Spec	Geography for service provision	Current Status (see key above)	Specification included
CS_15	Community Falls Service (Cannock Chase and Stafford and Surrounds Locality)	- Cannock Chase - Stafford & Surrounds		Y
CS_16	Community Nursing Service (Stafford and Surrounds, Cannock Chase and Seisdon Peninsular Localities)	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_17	District Nursing (SES)	South East Staffordshire & Seisdon Peninsula		Y
CS_18	Community Nursing Service (North and Stoke)	- North Staffordshire - Stoke-on-Trent		Y
CS_19	Dietetics	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_20	Specialist Continence Service	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_21	Children's Speech & Language Therapy Services (SALT)	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds - North Staffordshire - Stoke-on-Trent		Y
CS_22	Community Specialist Diabetes Service	- Cannock Chase - Stafford & Surrounds		Y
CS_23	Uttoxeter (East Staffs) Specialist Adult Dietetic Service – Nutrition Support (Adults)	East Staffordshire		Y
CS_24	Community MSK Service (IPOPS)	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_25	NIMS (North Staffordshire and Stoke-on-Trent Integrated Musculoskeletal Service)	- North Staffordshire - Stoke-on-Trent		Y
CS_26	Children's Continence Assessment Service (4-5 year olds)	- Cannock Chase - East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_27	Chronic Pain Management – East Staffordshire	East Staffordshire		Y
CS_28	Specialist Weight Assessment and Management Service (SWAMS) for Severe and Complex Morbid Obesity)	East Staffordshire		Y

Ref No.	Service Spec	Geography for service provision	Current Status (see key above)	Specification included
CS_29	Track and Triage	- North Staffordshire - Stoke-on-Trent		Y
CS_30	Wound Care Tissue Viability	- Cannock Chase - Stafford & Surrounds		Y
CS_31	Integrated Specialist Long Term Conditions Service	- North Staffordshire - Stoke-on-Trent		Y
CS_32	Community Heart Failure Service	- Cannock Chase - Stafford & Surrounds		Y
CS_33	Community Step Up IV Antibiotics	05G North Staffordshire - Stoke-on-Trent		Y
CS_35	Discharge to Assess (D2A) Community Beds	- North Staffordshire - Stoke-on-Trent		Y
CS_37	Brighton House – Rehabilitation, Reablement and Assessment Unit	- North Staffordshire - Stoke-on-Trent		Y
CS_40	Fracture Liaison Service	- North Staffordshire - Stoke-on-Trent		Y
CS_42	Review Health Assessments for Looked After Children (0-4 year olds, 'Hard to Reach' and Care Leavers)	- North Staffordshire - Stoke-on-Trent		Y
CS_43	Review Health Assessments for Looked After Children (0-4 year olds, 'Hard to Reach' and Care Leavers) South Staffordshire	- Cannock Chase - East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
CS_44	Provider Improvement and Response Team (PIRT)	Pan-Staffordshire & Stoke-on-Trent		Y
CS_54	Children's Physiotherapy	Pan-Staffordshire & Stoke-on-Trent		Y
CS_55	D2A Home First	Pan-Staffordshire & Stoke-on-Trent		Y
CS_56	Children's Podiatry			N
CS_57	Children's Dietetics			N
MH_01	Children's Community Nursing	- Cannock Chase - East Staffordshire - Stafford & Surrounds		Y
MH_02	Neuropsychology	- Cannock Chase - East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y

Ref No.	Service Spec	Geography for service provision	Current Status (see key above)	Specification included
MH_03	Assertive Outreach	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_06	Adult Eating Disorders	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_07	Acute Inpatient Service - Functional	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_09	Psychiatric Intensive Care Unit (PICU)	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_10	Community Dementia	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_12	Adult Community LD Teams	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_13	Intensive Support Service (IST) – Learning Disabilities	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_14	Children's Community LD	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_16	Perinatal Service – Outpatient/Community	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_17	Psychiatric Liaison Service	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_18	Paediatric Audiology	• 04Y East Staffordshire • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds		Y
MH_19	Children and Adolescent Mental Health Service (CAMHS)	• Cannock Chase • East Staffordshire • South East Staffordshire & Seisdon Peninsula		Y

Ref No.	Service Spec	Geography for service provision	Current Status (see key above)	Specification included
		Stafford & Surrounds		
MH_20	Community Paediatrics	04Y Cannock East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
MH_21	Community Complex Care Team	Pan-Staffordshire & Stoke-on-Trent		Y
MH_22	Individual Placement and Support (IPS)	Pan-Staffordshire & Stoke-on-Trent		Y
MH_23	SMI Mental & Physical Health Checks	- Cannock Chase - East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
MH_25	Specialist Dementia Service – In Reach – HMNP Stafford, HMP Oakwood & HMP Dovegate	- HMP Stafford - HMP Oakwood - HMP Dovegate		Y
MH_26	Participation Grant -Mental Health (MH), Children and Young People (CYP)	Pan-Staffordshire & Stoke-on-Trent		Y
MH_27	Maternal Mental Health	- North Staffordshire (in conjunction with NSCHT) - Cannock Chase - East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		N
MH_28	CYP Eating Disorders			N
MH_29	CYP Crisis			N
MH_30	EHCP Care Co-ordinator	- Cannock Chase - East Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
ASSOC-01	Derby Adult Ability Services	NHS Derby & Derbyshire ICB		Y
FRS_01	Falls Responder Service	North Staffordshire		Y
MICATS_01	MICATS – Community MSK Service	- Cannock Chase - Stafford & Surrounds		Y
SSN_01	Special School Nursing	- Cannock Chase - East Staffordshire - North Staffordshire - South East Staffordshire & Seisdon Peninsula		Y

Ref No.	Service Spec	Geography for service provision	Current Status (see key above)	Specification included
		Stafford & Surrounds		
SSN_02	Review Health Assessments for Looked After Children	- Cannock Chase - East Staffordshire - North Staffordshire - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
FSW_01	Frailty Service (Staying Well)	- Cannock Chase - South East Staffordshire & Seisdon Peninsula - Stafford & Surrounds		Y
FSW_02	Frailty Service (Staying Well) – Seisdon Locality Only	South East Staffordshire & Seisdon Peninsula		Y

*Geographical areas relate to previous Clinical Commissioning Groups (CCGs) as follows:

- 04Y - Cannock Chase CCG
- 05D - East Staffordshire CCG
- 05G - North Staffordshire CCG
- 05Q – South East Staffordshire & Seisdon Peninsula CCG
- 05V - Stafford & Surrounds CCG
- 05W - Stoke-on-Trent CCG

CONFIRMED SPECIFICATIONS

Service Specification No.	CS_01
Service	Community Specialist Asthma Nurse

Population and/or geography to be served	The Community Specialist Asthma Nurse service is a community located service for: Children and Young People (CYP) aged 0-18 years. For those CYP with an Education, Health and Care Plan (EHCP) this will be up to 25 years. This service is for CYP registered with a GP in Stoke-on-Trent. The asthma nurse service will utilise the available data and work collaboratively with referrers to identify those CYP that this service will be delivered to. CYP can be referred to the service by Secondary care consultant and Respiratory Clinical Nurse Specialists following attendance or admission to hospital or by the child's GP and walk-in centres/urgent care facilities, or primary care service, when a sequence of attendances/admissions has been identified, or there is a risk of potential admission, due to suspected or asthma exacerbation and deterioration due to inadequate management of the condition. The service shall ensure equal access for CYP irrespective of gender, religion or belief, race, or disability (learning and/or physical) and shall provide appropriate interpreting services.
Service aims and desired outcomes	Asthma is a chronic inflammatory respiratory disease which can affect people of any age, but often starts in childhood. It is a variable disease which can change throughout a person's life. Asthma is characterised by attacks (exacerbations) of breathlessness and wheezing, with varying severity and frequency of attacks. Asthma is a long-term condition but can be perceived as a mild disease and research shows that it is often not taken seriously enough. Asthma attacks are associated with variable airflow obstruction and inflammation within the lungs, which, if left untreated, can be life-threatening, however with the appropriate treatment can be reversible. The NHS National Bundle of Care for Children and Young People highlights that asthma is the most common long-term medical condition in CYP in the UK, with around 1 in 11 CYP living with asthma. Asthma is responsible for a large number of emergency contacts/A&E attendances and hospital admissions. The UK has one of the highest prevalence, emergency admission and death rates for childhood asthma in Europe. In the UK 1.1 million CYP have a clinical diagnosis of asthma, which averages at 3 children in every classroom. Every 20 minutes a child is admitted to hospital with asthma (Asthma UK 2018). Effective self-management is key to reducing these admissions. There are significantly higher rates of asthma incidence in black and minority ethnic (BAME) groups and Irish children. Poor air quality particularly affects Gypsy and Traveller communities due to the location of sites, near busy roads/motorways where air quality is poor. Asthma outcomes are worse for CYP living in the most deprived areas. NHSE/It's ambition is to reduce avoidable harm to CYP from asthma and improve their quality of life, achieved by taking a whole system approach to asthma management. This includes addressing environmental triggers, a comprehensive education programme, promoting personalised care, effective preventative medicine, and improved accuracy of diagnosis. There are a number of risk factors associated with

asthma, often in combination. These influences can be genetic and/or environmental (such as inhalation of allergens or chemical irritants).

Healthcare professionals should understand the dangers of air pollution, indoor air quality and parental smoking and ensure that the risks and potential mitigation strategies are discussed with the CYP and their family. Childhood asthma needs to be managed effectively across primary and secondary care to prevent exacerbations. Asthma deaths are largely attributable to avoidable factors. These include over-reliance upon reliever inhalers and under-prescription or use of preventer medications. The use of either short or long-acting relievers in isolation has been identified as a particular risk. Poor adherence to preventer treatments from any cause, intentional or non-intentional, is associated with worse outcomes.

For CYP under 19 years in Stoke-on-Trent (JSNA 2017) the current admission rate in the city remains significantly higher than England (435.5 (per 100,000) compared with 303.7). The rate of emergency admissions to hospital for lower respiratory tract infections among those aged under 19 has increased since 2012/13. There were 504 admissions locally in 2016/17. The current admission rate of 823.9 (per 100,000) is significantly higher in Stoke-on-Trent than the England average of 446.4.

The Asthma Nurse Service

The service will provide a timely and accessible community located asthma service to CYP following attendance or admission for emergency care review in community, general practice, or hospital facilities for acute exacerbation of suspected asthma. The service will work to the ambitions of the NHS LTP/NHS National Bundle of Care for CYP with asthma, putting CYP and their parents/carers at the heart of everything they do.

The Service is expected to be agile and responsive, keeping abreast of these changes and the changing needs of CYP and their families.

Service Aims, Objectives and Outcomes:

The service shall follow current guidance and standards, adopting relevant NICE guidance and standards as they are issued. The service aims, objectives and outcomes shall reflect this.

The service aims to:

- Provide a community/home-based service, including assessment, intervention, and management for CYP who have poorly controlled asthma.
- The asthma nurse service will utilise the available data and work collaboratively with referrers to identify those CYP that this service will be delivered to.
- Empower CYP and their family to manage asthma. This includes CYP with multiple episodes of viral induced wheeze with a probable diagnosis of asthma (as per referral criteria), post referral to service appropriately by increasing confidence and self-care skills.
- Provide evidence-based nursing care, education, and support in the home alongside developing and supporting robust care plans, service policy and monitoring of inpatient activity post discharge. To include awareness and identification in signs of deterioration, liaison with the patients' GP, education and other health and social care professionals to ensure they achieve their maximum potential.
- Ensure all CYP with asthma have an up to date written personalised asthma action plan (PAAP) in relation to diagnosis of Asthma / Viral induced wheeze (as specified above) which is recorded and made available to healthcare professionals working with the CYP.

- The following should be covered as part of the review: adherence, inhaler technique assessed (when necessary extra training provided), assessment of risk and severity, recent asthma control and where loss of control is identified immediate action is required, this should include escalation of responsibility, treatment changes, conversations about adherence and arrangements for follow-up.
- All patient encounters should be viewed as an opportunity to improve the understanding of CYP and their families. Regular assessment of inhaler technique and re-training where necessary are essential to ensure effective delivery of inhaled medications.
- Patient self-management should be encouraged to reflect their known triggers including stress, air pollution and seasonal allergies, e.g., Increasing medication before the start of the hay-fever season, when there is high or very high air pollution, avoiding non-steroidal anti-inflammatory drugs or by the early use of oral corticosteroids with viral- or allergic-induced exacerbations.
- Parents, CYP and those who care for or teach them, should be educated about managing asthma, working collaboratively with other MPFT teams. This should include emphasis on 'how', 'why' and 'when' they should use their asthma medications, recognising when asthma is not controlled and knowing when and how to seek emergency advice. To act as a resource to other health care professionals and education staff, including, advising, and guiding them as required, acting as an advocate for CYP and family.
- CYP, parents and carers should have access to relevant information/resource, that is accessible in such a way that is appropriate, on how they can manage asthma with regards to air pollution and indoor air quality e.g., digital apps, self-management programmes or signposted to resources and provided in a range of formats.
- Have conversations with parents and provide information regarding parental smoking and the associated risks and mitigating the risks associated with poor indoor air quality.
- Have resources to support parents who smoke by promoting harm minimisation education. Clinicians should be able to refer parents into smoking cessation service for this high-risk group and need to be equipped with the tools that enable them to do this
<https://www.makeeverycontactcount.co.uk/training/healthy-lifestyle-information/>
- To work to best practice guidance and service quality standards.
- Working alongside primary, secondary, and tertiary providers of care to proactively target support to families who may be struggling to manage their child's condition.
- To identify and refer into secondary care services when poor control exists with patient/parent consent, working collaboratively with CYP secondary/tertiary care teams and ICS (Integrated Care System).
- Support GP education and training to enhance support to families in the community.

Objectives

- To ensure that CYP and their families, once referred into the service have easy access to expert nursing advice and support through clear and consistent communication pathways.
- To work with Commissioners to ensure high quality, effective and value for money services are delivered.
- Ensure asthma is supported early and accurately - unrecognised and untreated

asthma leads to dangerous attacks and significantly impairs quality of life for CYP. Long term airway inflammation, airway remodelling and reduced lung growth.

- To find ways of improving the pathway as this contributes to better outcomes for CYP. Working as part of the ICS on CYP asthma improvements.

Local Defined Outcomes

- CYP known to the service and who meet the criteria shall be assessed in a timely manner
- The emotional needs of children are supported
- Improved patient experience
- This service contributes to a reduction in non-elective admissions for CYP with asthma

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	

NICE Quality Standards - contributes to improvements in the following outcomes:

- Young person's experience of transition
- Parents' and carers' experience of transition
- Health-related quality of life
- Social care-related quality of life
- Engaging with adults' services

Reporting / Outcomes

- Patient experience measures to be in place and regularly audited and fed back.
- Patient satisfaction surveys to include whether CYP and parents felt equipped to managing their asthma in relation to the impact of air pollution and of indoor air quality.
- To support a reduction in absenteeism data due (this data will need to be facilitated by education) to asthma to be collected on the CYP asthma dashboard - Absences due to asthma are recorded on the dashboard and the number of days absent should reduce favourably as systems become more established.

Staff Training for CYP Asthma Services

Staff shall access the asthma capabilities framework and complete the associated training appropriate to their role

- <https://www.educationforhealth.org/course/supporting-children-and-young-peoples-health-improving-asthma-care-together/>

	• https://uclpartners.com/work/air-pollution-key-resources-for-paediatricians/ All healthcare professionals working with CYP with suspected or diagnosed asthma should understand the sources of and the dangers and risk associated to air pollution, indoor air quality and smoking. To provide and potential mitigation strategies with the CYP and their family as part of their personalised asthma action plan and staff should be equipped with the tools that will enable them to do this. • To ensure staff have completed the appropriate level of training to include enabling them to have conversations about mitigating the risks associated with air pollution and parental smoking. All people involved in the management of CYP with asthma should be trained to the appropriate level depending on their role. ICS' will be held to account to ensure their CYP asthma workforce have met the required levels of training. The asthma nurse role will be required to work closely with CYP secondary/tertiary care teams, building and maintain effective relationships, taking a whole system approach to asthma management. They will work as part of the ICS towards NHS England and NHS Improvement's ambition which is to reduce avoidable harm to CYP from asthma and improve their quality of life. Working closely with ICS system colleagues and part of regularly communications and system learning approach for improvements. The Core Capabilities Framework is a 5-level tiered framework for anyone involved in the care of CYP with asthma has been developed (see the resource pack for the full framework). These have been approved by professional bodies, Royal Colleges, and relevant Arm's Length Bodies. • https://www.england.nhs.uk/publication/national-bundle-of-care-for-children-and-young-people-with-asthma/ The National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP), Clinical Audit of CYP Asthma 2021 report outlines three key national quality improvement priorities for providers of CYP asthma secondary care. They were chosen based on their strong evidence base and effectiveness for improving care and outcomes. The 3 Key areas are: • National QI priority C1: Record smoking status and exposure to second-hand smoke for 95% of CYP. The audit showed it was only recorded in 57.7% of cases (working towards). • National QI priority C2: Administer systemic steroids within 1 hour of arrival at hospital to 95% of CYP aged 6 years old or over, who have not received systemic steroids as part of pre-hospital care. The audit showed it was only recorded in 38% of cases. • National QI priority C3: Provide 95% of CYP with the following in their discharge bundle: i. Review or issue of a personalised asthma action plan (PAAP). ii. Check of their inhaler technique. iii. A follow-up appointment in a paediatric asthma clinic requested within 4 weeks.
Service description, care plan and	The CYP Asthma Service will deliver to the ambition of the NHS LTP and NHS National Bundle of Care for CYP with Asthma and align with the National Standards of Care which was drafted to ensure the NHS continues to build on the improvement recommendations and to ensure high quality of care for CYP with asthma.

location(s) from which it will be delivered	Service Description/Care Pathway Referrals are accepted from: • Secondary Care Consultant / Respiratory Clinical Nurse Specialist, GPs, Clinical Respiratory Nurse, walk-in and urgent care facilities • Referrals are accepted only with parental consent Special Educational Needs and Disabilities (SEND) The service will engage with other agencies (including education and social care) and parents/carers/CYP in the delivery of services related to special educational needs (SEND). This will include updating the Local Offer in line with any changes in the provision of this service and contributing to the health elements of EHCPs in a timely manner, so as to ensure Local Authorities can meet their statutory 6 week timescale and other associated timescales for EHCPs. The Service will take into consideration and respond to any requirements as part of the SEND Guidance https://www.gov.uk/government/publications/send-code-of-practice-0-to-25 relevant to their role. The Service will provide advice and support CYP, their parents and carers regarding arrangements for the assessment and provision of Special Educational Needs and Disability (SEND) legislation which requires that, the needs of CYP with SEND should be considered up to age 25, in some cases older young people (YP) will remain in a special school setting beyond their peers in mainstream schools. The Service will ensure that relevant information is included in the Stoke-on-Trent Local Offer including transition arrangements and that this information is kept up to date: http://localoffer.stoke.gov.uk/kb5/stoke/directory/home.page The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer (DCO) representing the CCGs. Transition The service will work closely with the CYP tertiary care severe asthma service for a smooth transition. For others their care would continue to be followed up in their local secondary decision as to the most appropriate setting for on-going care should be made jointly with the YP, their families and adult and paediatric teams. The process of transition should start some time before the actual transfer of care, from approximately 14 years onwards, but this should be based on developmentally appropriate care and the needs and wishes of the YP and their families). For those with an EHCP this can be up to 25 years of age. During this time the paediatric team should support the YP in gaining greater autonomy (when this is practicable) and ensuring they have appropriate knowledge of their condition, treatment, and self-management. This process should continue once the YP has transferred to adult care. Safeguarding The service shall be delivered in line with local inter-agency and internal safeguarding policies and procedures as determined by the Stoke-on-Trent Safeguarding Board. The service shall contribute to the high intensity multi-agency services for families where there are safeguarding and child protection concerns. This will be in line with 'A child-centered system'. The Governments' response to the Munro review of child protection' (Department of Education, 2011) and accordance with statutory guidance 'Working Together to Safeguard Children' (HM Government

2013) where CYP have an identified additional health need.

The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance (Working together to Safeguard Children 2018)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have and follow the services Was Not Brought Policy, to address any concerns regarding CYP not brought to appointments or for interventions.

<https://seriouscasereviews.rip.org.uk/>

The Provider's Premises

The service shall be delivered in the most appropriate and safe setting for the CYP and family: home, Clinic, Children's Centre, and School.

Interdependence with Other Services/Providers

The service shall work in collaboration with education/school staff within the school and link closely with others including (this is not an exhaustive list):

Stakeholder, interdependencies, and key relationships are:

- Patient, family, and carers
- Education
- Integrated 0-19 Health Visiting and School Nursing Service
- General Practice
- Secondary care consultants
- Secondary care nursing staff
- Community paediatricians

Applicable National Standards, Guidance and Policy

NICE, Quality Standard for Asthma (2013)

NICE, Diagnosis, monitoring and chronic asthma management Guidelines for Diagnosis and Monitoring of Asthma (2017)

NICE Management of Stable Asthma in Adults and Children (2017)

NHSE and NHS Improvement National Bundle of Care for CYP with Asthma (2021)

Global Initiatives for Asthma, Global Strategy for Asthma Management and Prevention (2021)

BTS/SIGN Guidance for the management of asthma (2019)

BTS/SIGN Asthma Guidance Quick Reference Guide (2019)

NHS National bundle of care for children and young people with asthma (2021)

NHS National bundle of care for children and young people with asthma: ICS deliverables (2021)

RCP National Asthma and COPD Audit Programme (NCAP) 2021-2023 Strategy

Asthma Quality Standard [QS25] NICE (2013)

Dupilumab for treating severe asthma with type 2 inflammation [TA751] NICE (2021)

Asthma: diagnosis, monitoring and chronic asthma management [NG80] NICE (Dec 2017)

	Mepolizumab for treating severe eosinophilic asthma [TA671] NICE (Feb 2021) COVID-19 rapid guideline: severe asthma [NG166] NICE (Apr 2020) Benralizumab for treating severe eosinophilic asthma [TA565] NICE (Mar 2019) Bronchial thermoplasty for severe asthma [IPG635] (Dec 2018) Reslizumab for treating severe eosinophilic asthma [TA479] NICE (Oct 2017) Measuring fractional exhaled nitric oxide concentration in asthma: NIOX MINO, NIOX VERO and Nobreath [DG12] NICE (Apr 2014) Omalizumab for treating severe persistent allergic asthma [TA278] NICE (Apr 2013) Inhaled corticosteroids for the treatment of chronic asthma in adults and in children aged 12 years and over [TA138] NICE (Mar 2008) Inhaled corticosteroids for the treatment of chronic asthma in children under the age of 12 years [TA131] NICE (Nov 2007) Inhaler devices for routine treatment of chronic asthma in older children (aged 5–15 years) [TA38] NICE (Mar 2002) Guidance on the use of inhaler systems (devices) in children under the age of 5 years with chronic asthma [TA10] NICE (Aug 2000) NHS Outcomes Framework Public Health Outcomes Framework Facing the Future: Royal College for Paediatrics and Child Health (RCPCH) (2018) Implementation Plan, Facing the Future: Standards for children with ongoing health needs (2017) 2nd Atlas of variation in risk factors and healthcare for respiratory disease in England (2019) Working together to Safeguard Children (2018) Safeguarding Children and Young People: roles and competences for health care staff (2019) Children and Families Act (2014)

Service Specification No.	CS_02
Service	Asylum Seeker & Refugee Health Team
Commissioner Lead	Sharon Cooper/Maria Anderson
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base National context

The number of applications for asylum in the UK, excluding dependents, has shown a gradual decline over the past year as detailed below in Table 1.

Table 1: Number of applications for asylum in UK

Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014
5,859	6,094	6,001	5,849	5,535

Table 2: Top ten asylum applicant producing countries by quarter, Q2 2014 (excl. Dependents)

	Q2 2013	Q2 2014	% change
Eritrea	202	739	+266%
Pakistan	823	610	-26%
Iran	625	432	-31%
Syria	367	374	+2%
Albania	296	339	+15%
Sudan	169	332	+96%
Sri Lanka	518	299	-42%
Afghanistan	243	236	-3%
Nigeria	248	208	-16%
Bangladesh	371	174	-53%

Local context

Stoke-on-Trent is a designated area for those seeking asylum and those who are refugees to be located.

Whilst the number of people seeking asylum has reduced nationally over the past year, as can be seen from the illustration below in Table 3, the number of people dispersed to Stoke-on-Trent has risen.

Table 3: Number of Asylum Seekers setting in Stoke-on-Trent

August 2013	May 2014	November 2014
545	545	655

2. Outcomes

NHS Outcomes Framework Domains & Indicators

Local defined outcomes

The Provider will deliver the following local outcomes:

- Engagement of client group;
- Improved overall access to healthcare;
- Prompt identification of health needs and referral into appropriate service;
- Increase in uptake of health screening programmes;
- Better knowledge and use of NHS Resources by service users;
- Increase knowledge of health issues in relation to the client group;
- Reduction of risk in terms of public health in relation to TB;
- Reduction of risk in relation to public safety and mental health.

3. Scope

Aims and objectives of service

The aims of the service is to provide an ongoing service to meet the health needs of the sustained population of asylum applicants and refugees within Stoke-on-Trent, delivering a reactive and proactive approach to streamlining access to healthcare whilst utilising voluntary and mainstream services in order to maximise health potential and integration into local communities.

The Provider will deliver the following objectives:

- Improve Access to Primary, Community and Secondary Care;
- Inform Service Users on the NHS Healthcare System;
- Signpost to other agencies as appropriate;
- Promptly identify Mental Health needs;

Screen the Client Group in terms of TB Status referring to the TB service as clinically appropriate;

- Facilitating GP Registration for the Client Group;
- Educational session to Clinical and Non Clinical Staff/Students;
- Act as information resource to other Professionals on Asylum issues.
- Support main stream services with complex cases

Service description/care pathway

The Provider will deliver a robust system to provide asylum seekers and refugees the opportunity to access health care and provide them with a sound working knowledge of the healthcare system whilst facilitating a positive public health approach.

The Provider will deliver the following service model:

- Facilitate prompt registration with a GP;
- Identify health needs specific to the population group;
- Undertake healthcare screening of asylum seeker and refugee population to include TB screening, Mental Health Screening and Sexual Health Screening;
- Maintain a database of selected information related to the asylum seeker and refugee population in Stoke-on-Trent;
- Information provision to assist in enabling services to be planned and targeted appropriately in order to promote equity of service provision and to tackle inequalities;
- Better integration of refugees and asylum seekers into local community and reduction of social isolation of vulnerable groups such as women and families;
- Increase awareness and understanding of the problems faced by refugees and asylum seekers by the various agencies and local populations;
- Optimise opportunity for asylum seekers and refugees to enjoy equitable healthcare;
- Promote and assist in communication between agencies involved with asylum applicants and refugees.

Service pathway

The Provider will facilitate access to GP's in collaboration with the required agencies.

The Provider will provide asylum seekers and refugees with TB, Mental Health and Sexual Health Screening assessments.

The Provider will refer/signpost patients to other core NHS services, where clinically appropriate in line with local pathways.

The TB screening will be undertaken in line with NICE Guidance.

The Provider will collate information to provide information on the asylum seeker population, in terms of nationality, language, immigration data and demographic data including immigration.

The Provider will undertake to support any professional requiring information about any issues relating to asylum seekers or refugees.

The Provider will assist the Local Authority on allocation of appropriate housing

The Provider will work in partnership with the dispersal provider to ensure asylum seekers and refugees follow the appropriate pathway.

Population covered

This service is aimed at individuals who are dispersed within the boundaries of Stoke-on-Trent regardless of whether they are registered with a GP or not.

Any acceptance and exclusion criteria and thresholds

This service is provided to all individuals within the boundaries of Stoke-on-Trent regardless of whether they are registered with a GP or not who are claiming asylum or who hold refugee status.

Exclusions to this Service are individuals who have entered the country for the purpose of a holiday; or who have entered the country with a Visa, work or study permit, this includes EU Migrants.

Interdependence with other services/providers

Referrals to the service will be received from variety of sources including self-referral and statutory organisations.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE Guidance relating to TB screening.

NICE Guidance relating to Mental Health screening. NICE Guidance relating to Sexual Health screening.

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

N/A

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

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

Refer to Schedule 4 Parts A-D

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Refer to Schedule 4 Part E

6. Location of Provider Premises

The Provider's Premises are located at:

Various locations around Stoke-on-Trent

7. Individual Service User Placement

N/A

Service Specification No.	CS_03
Service	Children's Community Nursing Services
Commissioner Lead	Simon Runnett, Commissioning Manager, South Staffordshire CCGs
Provider Lead	Joanne Heaney
Period	April 2023 to March 2024
Date of Review	March 2024

1. Population Needs

1.1 National/local context and evidence base

The national context and evidence base can be identified within the following documents:

- Children and Families Act (2014)
- Special educational needs and disability code of practice: 0 to 25 years, (2015)
- Disabled Children and the Equality Act (2010)
- Health and Social Care Act (2012)
- End of life care for infants, children and young people with life-limiting conditions: planning and management (2016)
- The NHS Long Term Plan (2019)
- NHS at Home: Community Children's Nursing Services (2011)
- A Guide to Children's Palliative Care "Supporting babies, children and young people with life-limiting and life-threatening conditions and their families" (2018)
- National Framework for Children and Young People's Continuing Care (2016)
- From the pond into the sea Children's transition to adult health services (2014)
- National Service Framework for Children, Young People and Maternity (2004)
- Making it better for Children and Young People (2007)
- Healthy Lives: Brighter Futures (2009)
- Getting it right for children and young people "Overcoming cultural barriers in the NHS so as to meet their needs (2010).
- Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing (2012)
- Every Child Matters: Change for Children (2009)
- Aiming High for Disabled Children: Better support for families (2007)
- Quality Standards-Children and Young People's Palliative Care (2019): Version 2, West Midlands Quality Review Service.
- Standards framework for children's palliative care (2015): Together For Short lives

1.2 National/local context and evidence base

The national context and evidence base can be identified within the following documents:

- Children and Families Act (2014)
- Special educational needs and disability code of practice: 0 to 25 years, (2015)
- Disabled Children and the Equality Act (2010)
- Health and Social Care Act (2012)
- End of life care for infants, children and young people with life-limiting conditions: planning and

management (2016)

- The NHS Long Term Plan (2019)
- NHS at Home: Community Children's Nursing Services (2011)
- A Guide to Children's Palliative Care "Supporting babies, children and young people with life-limiting and life-threatening conditions and their families" (2018)
- National Framework for Children and Young People's Continuing Care (2016)
- From the pond into the sea Children's transition to adult health services (2014)
- National Service Framework for Children, Young People and Maternity (2004)
- Making it better for Children and Young People (2007)
- Healthy Lives: Brighter Futures (2009)
- Getting it right for children and young people "Overcoming cultural barriers in the NHS so as to meet their needs (2010).
- Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing (2012)
- Every Child Matters: Change for Children (2009)
- Aiming High for Disabled Children: Better support for families (2007)
- Quality Standards-Children and Young People's Palliative Care (2019): Version 2, West Midlands Quality Review Service.
- Standards framework for children's palliative care (2015): Together For Short lives

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

- Care provided in the child's home or other appropriate settings.
- Reduction of psychological effect of hospitalisation and care in a clinical setting.
- Nursing and psychological support to child and family to facilitate social inclusion and prevention of hospitalisation.
- Reduction in disruption of normal family life.
- Provision of equitable service to children and their families
- Provision of health education, information etc. in an environment conducive to concordance.
- Facilitation of the mental health and well-being of the family.
- Prevention of admission and re-admission to hospital and facilitate the timely discharge of children from hospital. Support for families caring for a sick child at home to develop self-efficacy.
- Seamless transition between acute, community and primary care
- Where they wish to do so, children are provided with end of life care to enable them to die at home
- Children and Families have a positive experience of care provided
- CYP/Parents feel supported and empowered to care for their children at home

- Effective transition to adult services is supported
- The service shall contribute to EHC assessments for CYP known to the service, this will include providing reports/information regarding identified health needs and provision required in line with the statutory timeframes
- The service shall review EHC draft plans for which they have provided information to quality assure the accuracy of the information included in line with the specified timeframes
- The service shall engage and work in conjunction with the Designated Clinical Officer (DCO) for Special Educational Needs and Disabilities (SEND) to ensure compliance with statutory requirements

3. Scope

3.1 Aims and objectives of service

Aims

To provide Community Children's nursing services to Children and Young People residing within the boundaries of Staffordshire with varying health needs ranging from acute, complex and life limiting/life threatening. To work in an integrated way with Multi-disciplinary Team and other Providers:

- To deliver planned and unplanned care including assessment and treatment of the child whilst supporting the family in their own home
- Incorporate the use of evidence based digital and telephone assessments where safe to do so
- To work in partnership with all providers of paediatric care including GPs, acute care, Primary Care teams, local pharmacists and voluntary and third sector providers.
- To reduce the number of avoidable admissions to secondary care and presentations to emergency portals.
- To reduce length of stay in the acute setting, by delivering prescribed care safely and effectively within the child and family's home.
- To provide support and health education in order to facilitate self-care and independence. This may include providing training and support around specific children and participation in sharing of skills, knowledge and expertise.
- Work closely with commissioners of services to develop best practice and a high service quality standard.
- To work in partnership with the child and family, providing real choice as to how and where they receive nursing care and support.
- Encourage children and young people to gain control of their care including guidance regarding personal budget options including Continuing Health Care and Personal Health Budgets for the delivery of health care services
- The service shall be appropriate for a diverse population – i.e. ethnicity, linguistically, culturally, geographically, economically and educationally.

Objectives

- To ensure that primary and secondary care services, social services, education services and other agencies have easy access to child health expertise through clear referral criteria and pathways
- To ensure that children and their families once referred into the service have access to expert nursing advice and support through clear and consistent communication. Pathways including arrangement of direct admission for children when required.

- To ensure that children and their families once referred into the service have access to expert nursing advice guidance consistent with best practice. Support is given through clear and consistent communication pathways including arrangement of direct admission for children when required.
- To ensure integration with primary and secondary care through integration, communication, professional development and sharing of expertise.
- To enable parents and children to participate as active partners in health care by the use of care plans and pathways
- To develop appropriate and relevant service standards, to benchmark and quality assure for continued service development
- To develop appropriate data collection methods to facilitate clinical audit.
- Act as lead professional and advocate as appropriate
- A holistic approach to managing the child's health needs and supporting the family towards self-efficacy: including care co-ordination, liaison with other healthcare professionals as required, including 3rd sector, local authority and tertiary hospitals
- Monitoring and observation in agreement with the referrer and child/family.
- Participate in shared care with hospital and with General Practice
- Ensure parents have clear contact information for accessing support including out of hours care.
- Support and contribute to SEN assessment and care management approach.
- Support Continuing Care team in the assessment of needs for funding requests. Complete appropriate section of the Decision Support Tool (DST) for children with continuing care needs.
- Regular staff training and refreshing where required on updated policies and procedures, to ensure quality of service is maintained
- If required the team shall contribute to the training of some invasive procedures to parents, health, education and social services carers.
- The service will ensure that the service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with The Special Educational Needs and Disability code of practice 0-25 years.

3.2 Service description/care pathway

The Community Children's Nursing Service provides specialist nursing support in the child's own environment, in partnership with the child, family, carers and other professionals.

Complex Care - This is specialist support for someone with a chronic or long-term health condition, who requires extra assistance to manage their symptoms and day-to-day activities. Complex care can include any condition that requires clinical support, such as genetic conditions, acquired brain injuries or a neurological condition.

- A holistic all-encompassing approach to care throughout the child and family's journey.
- Specialist assessment of nursing needs aimed at avoiding admission to acute settings wherever appropriate and safe to do so.
- Care co-ordination as required by the child/family to optimise improved outcomes.
- To act as lead professional/key worker as appropriate
- Assessment and management of tissue viability at home/schools
- Monitor and ensure appropriate symptom management and pain control throughout assessment and intervention

Palliative Care – Caring for children and young people with life-limiting conditions is an active and total approach to care, from the point of diagnosis/recognition, embracing physical, emotional, social and spiritual elements through to death and beyond

- Assessment of nursing need for any child identified as having a life limiting/life-

threatening condition as identified in the Together for Short Lives Palliative Care Categories.

- Following initial assessment, the CCN team will provide support for vulnerable children and families on caseload that would benefit from at least 6-12 monthly assessment.
- A holistic all-encompassing approach to care throughout the child and family's journey.
- Agree and support an end-of-life care plan working in partnership with family, community and external partners
- Children/families receiving end-of-life care on call provision will be reviewed via community teams every 7-14 days, or after any significant changes in condition/symptoms.
- Monitor and ensure appropriate symptom management and pain control throughout assessment and intervention
- Assessment and management of tissue viability at home
- Access to support and advice during operational hours
- Access to specialist psychology (North) team only to support where available
- Access/signpost to respite/short break in-home services, provided within CCN service where commissioned
- All CYP will have Individualised Care planning including a symptom management plan
- All CYP will be supported with an Advanced Care Plan in partnership with parent and carers
- Access to 24-hour advice, support and symptom management at the terminal stage Access to continuing care funding to provide 24-hour support, as required, following Continuing Care funding protocols, as appropriate
- Respond and complete the CDOP process where appropriate

Hospital Avoidance and Facilitating Early Discharge

- Assessment of acute nursing needs and care management
- Nursing input delivering high quality unplanned care including assessment and treatment in a community setting aimed at avoiding admission to acute setting wherever appropriate and safe to do so.
- Assessment and care management of acute illness/conditions in agreement with referrer.
- Individualised care planning supporting independence.
- Monitoring and Observation in agreement with referrer and the child/family.
- Referral into other services if/as deemed appropriate in agreement with the child/family.

Constipation provision

To actively manage symptoms of constipation through advice/support and healthcare interventions thus avoiding admission to acute setting wherever appropriate and safe to do so, in Staffordshire

- Assessment and referral to appropriate part of the service : CCN or nurse led constipation clinic
- Advice and support on managing ongoing symptoms
- Education to enable CYP/parents to monitor and titrate treatment
- Liaison with GP, to communicate treatment plan
- Liaison with MDT and refer onto specialist service as appropriate

Non Direct Interventions

- The team may contribute where skills exist to support the training for some invasive procedures to parents, health, education and social services carers. This includes examples such as training for enteral feeding, care, changing and management of enteral

- feeding devices, administering injections and oral suctioning.
- Liaison with multi-agency professionals including local and tertiary centres.
- Contribute to co-ordinating continuing care packages including identifying the clinical needs of the child and family, with the referring hospital.
- Management of equipment owned and provided by the Community Children's Nursing Service.
- Consumables and equipment – sentence to reflect process to access needed
- ?? Children transitioning to adult care and equipment – procurement of these SR to confirm current status for this and agree sentence to reflect service development improvement plan here to cover all equipment and consumables
- Opportunistic and planned public health education and health promotion e.g. smoking cessation, healthy eating.

Respite Service

This service is available to children and young people identified with a life limiting/life threatening condition who are registered with a GP within the boundaries of the service where available. Home based respite care is available according to the Respite Matrix assessment scoring system. Staff are supported and trained by the community children's nurses. The respite on offer is available on a sessional basis within the week, and can include remaining within the family home, or transporting the children to outside (agreed with the family) environments. Families can access regular respite provision, whilst also being responsive to families in crisis with acute needs.

The criteria for accessing respite currently is children with a confirmed (by lead medics) palliative condition, and needs assessed by caseload holders.

Psychology Service North Only-

Psychology assessment, support and intervention is available to children and young people and their families identified with a life limiting/life threatening condition who are registered with a GP within the boundaries of Stoke on Trent and North Staffordshire CCGs.

Phlebotomy Service :

- North Team: UHNM are commissioned for paediatric phlebotomy
- East Team: Derby and Burton are commissioned to provide paediatric phlebotomy.
- West Team: Offer a paediatric phlebotomy clinic for GP requests in Stafford and Cannock up to the age of 10 years and dependant on developmental needs.
- CCN East and West -Will take blood specimens from babies under 12 months who have moved into the country and have not had the new-born bloodspot screening test usually undertaken within Acute Maternity Services, up to 10 per team per year.

Care Planning and Coordination

- The Community Children's Nursing Service shall be responsible for ensuring an assessment is carried out at the initial contact and reviewed in a timely and appropriate manner.
- A care plan shall be negotiated and agreed with all parties including the child and family. This shall be based upon local and national standards, policies, protocols and guidelines and shall take into account the wishes of both the child and family.
- Assessment and care plans for children with long term conditions developed in partnership with family and partners, for all children who are referred to the service.
- Key worker for children with complex/palliative care needs.

- Manage caseloads and coordinate care, discharging and referring patients as appropriate and in line with agreed pathways of care.
- Attend discharge planning for children going home from hospital with complex and long term medical needs
- Discharge letters to be sent to General Practitioner and parent/carer (and other healthcare professionals as appropriate).
- Parental consent and responsibilities shall be explicit within the care plan.
- The Community Children's Nursing Service shall, where required, contribute to any statutory assessments undertaken by or required by Specialised Services (social care), continuing care and Education.
- Service will seek to educate and empower children/young people and their carers to have a greater understanding of their condition and to be able to manage it.

3.3 Response time/detail and prioritisation

- Service will respond to all acute referrals for a child/young person with clinical priority taking precedence.
- Service will respond to all other non-priority referrals within 5 working days with a non-acute condition.

3.4 Clinical Delivery (each clinical request will have to be determined that the service can safely offer and where direct nursing support is required) - this list is not exhaustive:

- Implement packages of care from acute/specialist regional centres which fit referral criteria e.g.
- Administration of cytotoxic therapy
- Acute respiratory illness
- Phlebotomy within an agreed care plan
- Support for CYP requiring home oxygen
- Support for neonates on oxygen according to local Consultant pathways and best practice guidelines
- Administration of Intravenous Antibiotics
- Wound Care
- Post-surgical support
- Care of Central Venous devices
- Ongoing and interim support for children receiving enteral feeding
- Care of children receiving oncology treatment
- Palliative and End of life care in accordance with Together for Short lives criteria
- Acute eczema
- To act as lead professional/key worker as appropriate
- To support and develop decision making tools
- Participate in shared care with hospital and with General Practice
- Promote and support self-care
- Monitor and ensure appropriate pain control throughout assessment and intervention
- Ensure parents have clear contact points for advice and support
- To work with and develop new clinical and multi-agency pathways, including integrated care pathways
- Support and contribute to SEN assessment
- Support all parents and carers by completing the relevant section of the Decision Support Tool (DST) for children with continuing care needs, whom are resident on the CCNT caseload.
- Where applicable the service will support the CYP and their family/carers to pursue a personal healthcare budget. At the providers discretion within their scope of competency.

Transition to Adult Care

- Transition shall be planned where transition in agreement with parent and CYP is clinically indicated and where adult services are commissioned.
- Transition will include working with the multidisciplinary teams making an active contribution to healthcare plans
- Proactive engagement with adult services (Health and/or Specialist Services including Social Care) shall commence as the child reaches 14 years of age where it is envisioned that specialist health care will be needed beyond the age of 18 years.
- Facilitation of transition from paediatric services to adult services, with a particular focus on children with long term conditions, disability or who have life limiting conditions.
- Transition planned to commence on referral or at least 6 months prior to transition, where transition is clinically indicated and services are commissioned, however it is reasonable to assume it may commence earlier with more long-term conditions.
- Where CYP have complex healthcare needs, a flexible approach will be offered so that the CYP will only be discharged from CCN caseload when care needs are being met safely by Adult Services.

If the service user is consenting and only where the nature of illness or presenting condition allows a safe navigation to Adult Community Nursing Services a referral shall be made. Any such cases shall be discussed and agreed with the service user in the first instance and the care plan discussed and agreed between the Community Children's Nursing Service and the Adult Services.

An individual transition care plan between paediatric and adult health services should provide coordinated and uninterrupted healthcare to avoid negative consequences. Adequate time must be given to access appropriate training and procurement of equipment/consumables and engagement with adult services.

Multi agency support must be provided to young people and their families of which The Community Children's Nursing Service shall contribute to ensure successful transition. The child/family will benefit from help in developing skills in communication, decision making, assertiveness and self-care, helping them to manage social, educational and employment opportunities and challenges and develop the independent living skills which underpin fulfilment and well-being.

3.5 Population covered

The service will be available to children and young people aged 0-18 years of age (includes those up to 19 in full time education and 25 years for SEND) and who are registered with a GP in the geographical boundaries of Staffordshire and Stoke-on-Trent.

If a person is residing temporarily within the area, but are registered with a GP elsewhere (i.e., student or child placed in the area by another authority) host CCG will be responsible for payment under the Responsible Commissioner guidance

3.6 Any acceptance and exclusion criteria and thresholds

Referral Criteria

- The child or young person is aged under 18 years, with the following exception:
 - up to 18 years if already under the care of or referred by a paediatrician/children's urgent care team
 - Up to 25 years if they have a learning disability, although this may be negotiated with Adult Community Services, and may require a joint approach dependant on the presenting condition.

- For any new period of acute illness, the child/young person will need to have been assessed and referred with a diagnosis by a medical professional before the referral can be accepted
- The child must be thought to have a specific health care/nursing need, either acute or more complex in nature that requires the expertise of a community children's nurse.
- The child and family must be aware of the referral and have consented to the referral.
- Medical Management of the child remains the responsibility of the referring GP, Consultant or Tertiary Care specialist.
- The service has direct referral route to Consultant or Acute Secondary care provider as necessary and appropriate.
- If a referral to the community children's nursing service is not accepted, the child and family shall be directed to another service via the initial referrer.
- Referrals will be received from any health care professional

Exclusion Criteria

- Children who require emergency or urgent medical attention
- Children who require simple dry dressings
- Dispensing of medication or the routine collection and delivery of prescriptions
- Administration of oral medications, and medications that are not appropriate for safe administration in the community
- Children with long term ventilation that require consumables only and no nursing input
- Children with mental health problems, which may affect their ability to take medication or undertake personal care.
- Requests to check Plaster of Paris
- Requests for equipment where CYP is not known to CCN service or has no identifiable complex healthcare needs
- Children who need assistance with personal care
- Behavioural feeding difficulties
- Assessment of social care needs
- Providing assessment on request for CYP who receive assessments from another agency/organisation
-

3.7 Hours of Operation

- 7 days per week, 9:00 – 21:00 and 9:00 – 17:00 on Public Holidays

3.8 Discharge Planning

Consumables £

Discharge plans to be completed in conjunction with partner organisations and in partnership with the child/young person, parent/carer and multi-agency partners who are involved with the family.

Children and Young People will be discharged from the CCN Service when:

- The CYP no longer requires the service – **all health needs are being fully met by family or external provider**
- Care has been transferred to another provider
- Was not brought to clinics in accordance with provider policy and pathways which may result in discharge. The referrer will be notified at point of discharge. However, if there are concerns regarding the client's condition and if there are safeguarding concerns, Child Protection policy will be followed in line with Staffordshire LSCB and National guidance.

Documentation in the form of paper or electronic letters or emails will be provided to the Parent, main carer or medical professional required to be notified of the discharge. The health record will also include an electronic discharge entry

Service will seek to educate and empower children/young people and their carers to have a greater understanding of their condition and to be able to manage it.

3.9 Safeguarding

Safeguarding

Work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance (Working together to Safeguard Children 2018):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

As appropriate, children's and Adult safeguarding procedures should be adhered to in all cases.

Chaperone Policy

Have appropriate chaperone policies aligned to current national guidance:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

Have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:

https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3.10 Special Educational Needs and Disabilities (SEND)

The service will take into consideration and respond to any requirements as part of the SEND Guidance:

<https://www.gov.uk/government/publications/send-code-of-practice-0-to-25> relevant to their role.

The Service will provide advice and support children and young people, their parents and carers regarding arrangements for the assessment and provision of SEND. Special Educational Needs (SEND) legislation requires that the needs of children and young people with Special Educational Needs should be considered up to age 25, in some cases older young people will remain in a special school setting beyond their peers in mainstream schools.

The Service will ensure that relevant information is included in the Staffordshire Local Offer including transition arrangements and that this information is kept up to date:

<https://www.staffordshireconnects.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

3.11 Broader Information regarding the needs of Children & Young People in Staffordshire

The Joint Strategic Needs Assessment for Staffordshire sets out some of the health and wellbeing needs for Children and Young People. The full document can be accessed at:

<http://moderngov.staffordshire.gov.uk/documents/s94660/Childrens%20JSNA%20FINAL%20April%202017.pdf>

Supporting this are a range of profiles and additional data relating to children and young people which are available at:

<https://www.supportstaffordshire.org.uk/news/staffordshire-observatory>

The Service is expected to keep abreast of any changing needs of the children and young people population in Staffordshire and ensure that it is agile and responsive to meet this.

Regular, local insight from children, young people and their families should be fed into this process and drive ongoing service improvement and development.

3.12 Interdependence with other services/providers

Stakeholders and interdependencies shall vary for individual services and service users but shall include:

- Paediatricians
- General Practitioners
- Acute Hospitals including regional and national centres
- Special school nursing service
- Allied Health Professionals
- CAMHS
- Learning Disability Services
- Health Visitors
- Targeted Intervention Service
- Public Health Advisory Service
- Equipment Services
- Parents and Carers
- LA – Education
- LA – Specialised Services
- Voluntary Organisations
- Hospice
- Adult Services
- Complex Care Team
- Agency Providers

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

CCN teams will work to current National Standards, NICE Guidelines, Statutory Guidelines and evidence base including :

- Transforming Community Services: Ambition, Action, Achievement Transforming services for Children, Young people and their families (2009).
- The QNI/QNIS Voluntary Standards for Community Children's Nurse Education and Practice (2018).
- Transition from children's to adults' services NICE Quality standard [QS140] (2016).
- End of life care for infants, children and young people with life-limiting conditions: planning and management NICE guideline [NG61] (2019).
- Transition from children's to adults' services for young people using health or social care services NICE guideline [NG43] (2016).
- Working Together to Safeguard Children Statutory framework: legislation relevant to

safeguarding and promoting the welfare of children. (2018).

- Equality Act 2010
- Health and Social Care Act 2012
- Care Standards Act 2014
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NHS at Home: Community Children's Nursing Services (2011)
- The National Service Framework for Long-term Conditions, DH (2005)
- NSF for Children, Young People and Maternity Services., DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- DH (2003) Getting it right: National Service Framework for Children. Standards for Hospital Services.
- Working Together to Safeguard Children (2013)
- the future for community children's nursing: challenges and opportunities (RCN, 2014)
- RCN Children's Community Nursing Promoting Effective team working for children and their families (2003)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)
- The service will ensure that the service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with The Special Educational Needs and Disability code of practice 0-25 years.

5. Applicable quality requirements and CQUIN goals

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

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

Provided in most appropriate and safe setting for the child and family – Home, Clinic, Children's Centre and School.

7. Individual Service User Placement

N/A

Service Specification No.	Community Continence Service (Adults and Children and Young People)
Service	CS_04
Commissioner Lead	Sharon Cooper
Provider Lead	Ian Turner
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 - Urinary incontinence (UI) affects 1 in 3 women aged 18+ (35,000:100,000 women), but less than 20% are actively treated - Lower urinary tract symptoms (LUTS) affect 2.7% of men aged 18+ and 35% of men aged 60+ - UI and / or faecal incontinence affect 50-80% of care home residents For a standard population of 250,000, assuming that around 40% are women aged 15 years or older (100,000), the average number of women requiring referral into a bladder and bowel dysfunction service would be 800 per year (0.80% of the female population). For an average practice with a list size of 10,000, assuming that around 40% are women aged 15 years or older (4000), the average number of women requiring referral into a bladder and bowel dysfunction service would be 32 per year (0.80% of the female population).¹ - Faecal incontinence (FI) is a stigmatising condition that is likely to affect over half a million men and women in the UK. Epidemiological information shows that between 1% and 10% of adults are affected. - It is likely that 0.5–1.0% of adults experience regular FI that affects their quality of life. FI is closely associated with age (prevalence is about 15% in adults aged 85 years living at home) and is even more common in residential and nursing homes (prevalence ranges from 10% to 60%). Conservative management/treatment for urinary/faecal incontinence is recommended to include lifestyle, physical, behavioural and drug therapy interventions NICE estimates about 900,000 children and young people (CYP) (aged 5-19 years) have bladder or bowel dysfunction. - It is estimated that about 600,000 CYP in the UK suffer from nocturnal enuresis, however prevalence data suggests this decreases with age. - Estimates suggest prevalence of faecal incontinence in CYP is: 1 in 30 – aged 4-5 years 1 in 50 – aged 5-6 years 1 in 75 – aged 7-10 years 1 in 100 – aged 11-12 years - Benninga M.A et al (2013) reports that the worldwide prevalence figures for constipation in CYP vary widely and it is estimated to range between 0.3% - 28%. - There are 770,000 disabled CYP in the UK, 1 in 33 CYP (aged 5-16) with a physical disability may also have continence problems. Limited research suggests that between 0.45% - 8.6% 0-18 year olds have a moderate to severe learning disability.	
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 Locally defined outcomes

- Improved outcomes for patients i.e. quality of life.
- High patient, carer and referrer satisfaction.
- Improve patient self care and prevention.
- Increase number of patients cured or symptoms alleviated
- Delivery of patient centred care through integrated service delivery across the local health economy.
- Reduction in inappropriate reliance on products for the containment of urinary/faecal incontinence.
- Provision of comprehensive activity data.
- Reduction in avoidable secondary care attendance, admission.

3. Scope

3.1 Aims and objectives of service

The aim is to provide a comprehensive, patient-centred, easy to access adult and children and young people continence service in the community, which delivers high quality, efficient services in line with national guidance and local requirements.

The service Objectives are:

- To provide improved access to services closer to home.
 - To provide a nurse led community based model, with assessment and investigation where appropriate, thereby reducing inappropriate/unnecessary referral to secondary care
- To reduce waiting times to access the service and deliver treatment to enable patients to reach their individual treatments goals sooner. This could include an improved quality of life, return to work, access to education and increased management of activities of daily living
- To deliver clinically effective treatments, that reduces the demand on secondary care services and reduces the need for more costly interventions.
- To provide community services that have a strong emphasis on patient education and self- management, thereby promoting active, healthy lifestyles and reducing recurrence of injury or illness.
- To reduce unnecessary treatment and inappropriate reliance on products for the containment of urinary/faecal incontinence
- To provide the best possible outcomes for women, men and their carers through identification and intervention, resulting in alleviation of symptoms and/or cure

3.2 Service Description/care pathway

Adult

The service required is for the delivery of a community based provision of assessment, treatment and management of adult continence conditions in line with the acceptance and exclusions criteria and service requirements outlined in this specification in accordance with NICE guidance.

Maximum wait time of 6 weeks for continence appointments.

The Provider must encourage patients to be more involved in their own care and empower them to take further responsibility for wellness. The Provider must provide information to patients (and carers) regarding self-care, in accordance with best practice. Providers must ensure that this is undertaken at the outset and continued throughout the whole package of care and that a self-care management plan is provided to the patient upon discharge from the service.

Provision of pad products for continence shall be based on clinical need, managed proactively and be the last line of resort for patients in order to deter overreliance. The use of Digital Health shall increasingly support continence problems as an alternative short term, cost effective solution.

Children and Young People

The service shall deliver a coordinated and evidence based approach to support children and young people with complex continence needs where first line treatment from universal services (GPs, PH Advisors, Health Visitors, School Nurses) have not led to a resolution to their problem.

The service shall support individuals with special needs and more complex bladder and bowel problems and respond effectively to the physical, psychological and social needs of any child or young people with bladder and/ or bowel dysfunction and toileting difficulties.

The service shall:

- Provide expert advice and support to parents, carers and health professionals including training and supervision of procedures.
- Undertake comprehensive bladder and or bowel assessments and appropriate training to health professionals followed by appropriate treatment programme and care plans.
- Support the management of prescribed medication in partnership with the GP and Community Paediatrician as appropriate.
- Support the provision of appropriate products for children and young people with identified continence difficulties following assessment.

The service shall deliver support to the child, young people and family in partnership with other health professionals. They shall ensure a holistic approach to managing the child's condition and supporting towards self-efficacy; including care coordination, referrals onto other services (such as acute services), teaching and support with healthcare interventions.

Population covered

Adults

This service will be available for patients 18 years and over registered with a North Staffordshire and Stoke on Trent GP.

Housebound patients who are unable to attend clinic will be referred to District Nursing. Patients with complex continence needs will be seen by the specialist continence service.

Children

The Child or young person is aged 16 years or under, with the following exceptions:

The young person is in receipt of an Education, Health & Care Plan and registered with a GP in Stoke-on-Trent or North Staffordshire up to the age of 18 years. Depending on the presenting condition and personal circumstances, adult and children's services will agree where the young person's need can best be met in consultation with the young person and their family.

Any acceptance and exclusion criteria and thresholds

Adult

The service will accept referrals for patients 18 years or over with urinary and/or faecal incontinence with referral to secondary care as indicated below:

Female Urinary Incontinence	
URGENT	ROUTINE
• Microscopic haematuria in women aged 50 years and older • Visible haematuria • Recurrent or persisting UTI associated with haematuria in women aged 40 years and older • Suspected malignant mass arising from the urinary tract	• persisting bladder or urethral pain • clinically benign pelvic masses • associated faecal incontinence • suspected neurological disease • symptoms of voiding difficulty • suspected urogenital fistulae • previous continence surgery • previous pelvic cancer surgery • previous pelvic radiation therapy
Male urinary Incontinence	

- Haematuria
- Raised PSA >50 and / or prostate feels abnormal
- Renal impairment which may be due to obstructive uropathy
- Urinary retention >200ml
- Persistent bladder or urethral pain
- Suspected neurological diseases – refer as appropriate
- Nocturnal enuresis
- Stress incontinence unless post prostatectomy
- Failed previous surgery / procedure

Faecal Incontinence

Urgent referral

- Rectal Bleeding
- Rectal Mass
- Change in Bowel habits

Children

The service shall be provided in accordance with section 3.3.

Referrals shall be accepted from GPs, Schools Nurses, Health Visitors, Children's Community Nursing Team, Hospital at Home and other allied health professionals (such as therapists).

Referrals will be triaged, assessed and accepted via a coordinated referral system to best meet the needs of the child or young person. Any referrals not accepted will be returned with reason as stated.

- Referrals shall be accepted for patients requiring intermittent catheterisation, urethral catheterisation, suprapubic catheterisation and management of mitronfonoff.
- The planning and delivery of individualised training plans to support children and young people, clinicians (i.e. community children's nurses) carers (i.e. parents) and appropriate others in the on-going care and management of the above clinical devices.
- Provide a point of contact for patients and carers
- With regard to the management of urinary and/or faecal incontinence and following completion of an initial/basic assessment by the first-line clinician (i.e. community children's nurses), undertake specialist assessment in order to supply the most appropriate absorbent or containment continence products.
- Provide training, advice and support regarding the provision and management of absorbent or containment continence products (i.e. nappies and continence pads)
- Refer to and work collaboratively with other specialist continence services such as the enuresis clinic and constipation clinic.
- Assist and advice regarding the transition from children's services to the adult continence service.

3.5 Independence with other services/providers

Adult

To ensure a patients experience is a streamlined journey and a good experience the provider must work collaboratively with the commissioner, primary care and secondary care providers and the interface service to deliver services in an organised and cohesive manner. Where appropriate the provider must demonstrate effective links with other statutory providers and voluntary sector organisations.

The service will provide relevant training to social care services, care home staff, GPs, practice nurses, community and hospital nurses, health visitors

The provider should work using an integrated approach with other agencies caring for people with incontinence.

Children

The service shall link closely and where required work in partnership others, including:

- General Practice
- Community Paediatricians
- Health Visitors
- School Nursing
- Public Health Advisors
- Children's Community Nursing Team
- Hospital at Home
- Allied Health Professionals (therapists)
- Mental Health and LD services

4. Applicable Service Standards

4 Applicable national standards (eg NICE). Applicable standards set out in Guidance and/or issued by a competent body. Applicable local standards:

- Essential Standards for Quality and Safety http://www.cqc.org.uk/sites/default/files/media/documents/essential_standards_of_quality_and_safety_march_2010_final_0.pdf
- The 2001 National Service Framework for older people called for the establishment of integrated continence services for older people. http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004832
- Essence of Care 2010 Benchmarks for Bladder, Bowel and Continence Care <http://www.tsoshop.co.uk/bookstore.asp?FO=1161150&DI=627604>
- Urinary continence service for conservative management of urinary continence commissioning guides 2008. <http://www.nice.org.uk/media/879/50/UrinaryIncontinenceCommissioningGuide.pdf>
- NICE guidance Urinary incontinence: The management of urinary incontinence in women <http://www.nice.org.uk/nicemedia/live/14271/65143/65143.pdf>
- NICE guidance for Faecal Incontinence 2007 <http://www.nice.org.uk/CG49>
- NICE guidance for Male Lower Urinary Tract Symptoms (2010) <http://www.nice.org.uk/nicemedia/live/12984/48557/48557>
- Cost effective commissioning for continence care - all Party Parliamentary Group For Continence Care Report 2011 <http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf>
- National Audit of Continence Care Combined Organisational and Clinical Report September 2010 Commissioned by The Healthcare Quality Improvement Partnership.
- Conducted by:
- Clinical Standards Department, Royal College of Physicians, London <http://www.rcplondon.ac.uk/sites/default/files/full-organisational-and-clinical-report-nacc-2010.pdf>

5. Applicable quality requirements and CQUIN goals

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

Schedule 4 C Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Patient Experience	>95% - Have a positive experience	EleLite – quarterly performance - sample size to be agreed May 14	As identified in General Condition 9
Quality of Life	>95%	ICIQ questionnaire – Annual report – sample size to be agreed May 14	As identified in General Condition 9
Number of adults cured or symptoms alleviated whilst within the service or post discharge	>95%	Indicators pre and post treatment to demonstrate improvement / cure rate	As identified in General Condition 9
Number of patients accepted	>95%	Monthly performance report	As identified in General

to the service and seen within 6 weeks			Condition 9
Clinical audit using NICE standards / Essence of Care Benchmark	Annual report	Audit report	As identified in General Condition 9

Schedule 6 A - Local reporting requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Monthly Activity Report to include the following:	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	All
Number of referrals (by source)	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
Number of contacts by: Triage Telephone Face to Face	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
Number of first attendances	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
Number of follow up attendances	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
First to follow up ratio	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
Number of people cared for by service/caseload	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
Number of patients discharged from the service (completed episodes)	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
No of annual reviews completed by the service	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
DNA rate	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	
Number of signposted referrals to: Acute District Nursing Advice and Guidance	Monthly	Excel Report	Submit to Co-ordinating Commissioner within 10 Operational Days of the end of the month to which it relates.	

5.2 Application CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Providers are located at:

7. Individual Service User Placement

Service Specification No.	CS_05
Service	Children's Occupational Therapy

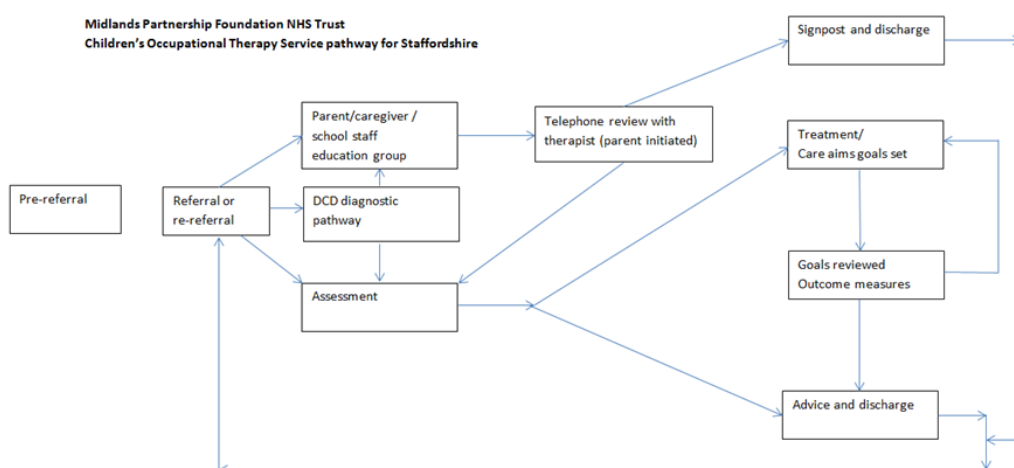
Population and/or geography to be served	1.1 Population covered The service will be available to children and young people aged 0-18 years of age (including those up to 19 in full time education) and who are registered with a GP within the geographical boundaries of Staffordshire and Stoke on Trent Integrated Care Board (ICB).		
Service aims and desired outcomes	<u>2.1 NHS Outcomes Framework Domains & Indicators</u>		
	Domain 1	Preventing people from dying prematurely	
	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 Each child, whose referral is accepted, will be offered a pathway of intervention that is the most suitable to meet their needs, based on the information provided in the referral and any secondary information gathered as part of the triage process. The service is moving towards a Partnering for Change (P4C) Model (Missiuna C., et al., 2012), aiming to increase Occupational Therapy support in the Universal and Targeted service tiers, allowing therapists to focus their specialist service offer to those children who most need it and who can most benefit from it. Use of the Staffordshire Risk Matrix and the Care Aims Model will be used to identify clinical risk when making clinical decisions. In this way the service can target its resources to address the needs of the children who will most benefit from intervention. 2.3 Aims and objectives of service Occupational therapy enables people to participate in daily life to improve their health and wellbeing. Daily life is made up of many activities (or occupations). Occupations for children or young people may include self-care (getting ready to go out, eating a meal, using the toilet), being productive (going to nursery or school, or volunteering) and leisure (playing with friends or doing hobbies). (Royal College of OT, 2019)		

	Occupational Therapy is an occupation-focused profession. Hence the aim of intervention is to increase the person's Occupational Performance. Occupation itself (meaningful purposeful activity) is used as the main intervention medium. The overall aim of the Children's Occupational Therapy service in Staffordshire and Stoke On Trent is to increase the Occupational Performance of children who have either a physical disability or a motor coordination difficulty, thus increasing their capacity to: • Participate in their home life, school life, and in wider society • Become as independent as possible in childhood and adulthood • Reach their full potential • Achieve a good quality of life Objectives • promote the occupational performance of children in Staffordshire and Stoke On Trent who have a physical disability or a motor coordination difficulty. • use available resources to achieve the maximum advantage to the population of children with physical disabilities or motor coordination difficulties, ensuring those that have the capacity to most benefit are prioritised. • triage and direct referrals through a pathway which meet the needs of the child and family in an efficient way. • where specific need is identified, provide safe, competent, clinically effective, individualised, and evidence-based interventions, to those children who can most benefit. • provide group interventions to children where appropriate. • provide a range of intervention media to meet the diverse needs of the population and the diverse stakeholders who ask for support (eg provide advice, information, training, skill sharing and coaching to parents, carers, education and health professionals). • support children, families, caregivers and education staff to understand the child's condition, level of ability and potential for change. • where children are known to the service, provide advice and assessment when needed towards the statutory requirement for a child with special educational needs including Education, Health and Care plan (EHCP) where an intervention need has been established, use graded occupation (meaningful, purposeful activity) with appropriate goals to promote the child's occupational performance.
Service description and location(s)	3.0 Service description/care pathway

from which it will be delivered	3.1 Following recommendations by Hutton et al British Journal of Occupational Therapy (BJOT2016) the service will move towards implementing the “Partnering for Change (P4C)” model. https://www.partneringforchange.ca/what-is-p4c/model/ 3.2 Rather than focusing only on referred children, the Occupational Therapy team will aim to work towards having input throughout the tiered hierarchy of needs as follows: • <u>Universal Tier</u> (giving general advice that supports the whole population of children with their occupational performance skill development). This could comprise of training, leaflets, resource packs, consultations, information, advice and guidance in occupational therapy to parents/carers, health visitors, school nurses, GPs and school staff. Or an Occupational Therapist may work alongside a teacher/education staff to help make the classroom more supportive of all children’s occupational performance. • <u>Targeted Tier</u> (helping schools set up programmes for children who are falling behind or identified as being at risk). This might entail helping a school set up a handwriting group, a motor skills programme or a touch typing course for selected pupils to attend. • <u>Specialist Tier</u> (addressing the specific needs of children who are identified as needing professional intervention, following the referral of a named child to the service.) Specialist assessment and intervention should be evidence based and in line with national guidelines. • <u>Partnership Working</u> Parents, carers, education staff and others are key partners to the success of delivering effective community children’s therapy services. Through training, skill sharing and coaching, partners will be able to gain the skills they need to support the occupational performance of children in Staffordshire and Stoke on Trent. 3.3 The service will be provided for a wide range of conditions/syndromes including: Developmental Co-ordination Disorder, Cerebral Palsy, Hemiplegia, Head Injury, Juvenile Chronic Arthritis and Upper Limb Deficiency. In the north of Staffordshire, the service will work collaboratively with the Occupational Therapy service (CAMHS-Disability team) provided by Combined Healthcare NHS Trust to meet the needs of children with learning disabilities with physical conditions/development needs. The service will work collaboratively with colleagues across all children services to meet the needs of those children who have physical disability/difficulty impacting on their occupational performance. 3.4 Service Pathway

All referrals will be triaged and assigned to an appropriate course through the pathway, prioritising referrals based on clinical risk/urgency. If more information is required, the parent/guardian and/or education setting will receive a questionnaire to complete which enables them to highlight their main concerns about the child's occupational performance.

Figure 1: Pathway diagram
Would require diagram to state Staffordshire



3.5 Motor Coordination Referrals

- Children will be treated through the Parent Education Group.
- Children and their carers will be supported to develop goals and a bespoke care plan.
- Following treatment carers will be offered a review appointment (usually telephone) to address any further needs if required. If the carer decides that a review is not required/does not actively contact the service for a review the child will be discharged from the service. This offer will be communicated to both the carer and referrer on completion of the Parent Education Group (this will include the specific date by which the carer must contact the service for review to stop automatic discharge).
- Following review the child will either be discharged, receive advice or individual/group therapy depending on need.

3.6 Condition Specific Referrals

- Children will be assessed and treated in the most appropriate setting, either individually or in a group where appropriate.
- Following assessment all children will have a jointly agreed goal with clear objectives and a review date for completion (where appropriate).

3.7 Assessment

Assessment will be offered to eligible children and young people who need it. This may be arranged directly from referral or following the above course

attendance. Assessment may take place as part of a group or individually. Following assessment, recommendations will be made verbally and in writing. These may include the recommendation that a child would benefit from treatment to support their occupational performance. Where this is the case the child will have a jointly agreed occupational performance goals and a review date.

3.8 Treatment

The Provider will:

- Deliver appropriate and proportionate therapeutic interventions across the continuum of universal, targeted and specialist need
- Deliver interventions designed to promote a child's occupational performance with agreed outcomes agreed for each child
- Deliver interventions that are evidence-based and in line with practice guidelines
- Deliver interventions that are flexible and accessible
- Educate parents/carers to enable them to support their child's occupational performance
- Provide training for education staff to support their pupil's occupational performance

3.9 Outcome review

The Provider will:

- Evaluate the achievement of agreed goals with the child, parent or education setting as appropriate
- Consider whether another 'care aim' is appropriate or whether the child's episode of care is complete, and discharge should follow

3.10 Discharge

Following completion of episode of care, the child will be discharged. Parents/carers/referrer will be advised, and information given on how to access the service in future if required.

If carers fail to attend an appointment, they will be contacted in writing and advised that unless they contact the service by a given date it will be assumed that they no longer wish for their child to be seen by the service and they will therefore be discharged. However, if there are child protection concerns the child protection policy is to be followed and discussion will be undertaken with relevant agencies.

This letter will be copied to the referrer.

3.11 The service will:

- Strive to continuously improve through reflective practice and by interpreting data collected from child outcome measures.
- Participate in national and local evaluation and research

- Where appropriate, for children with open referrals and where assessments have been completed, contribute to Early Help Assessment (EHA)
- Use information from other assessments, including integrated assessments under EHA, to inform occupational therapy assessments
- Where appropriate (for children with open referrals and where individual assessments have been completed), contribute to Education Health and Care Plan assessments for children and young people. This will include providing reports/ information regarding identified health needs and provision required in line with the specified timeframes
- Review EHCP draft plans, when received, for which they have provided information to quality assure the accuracy of the information included in line with the specified timeframes
engage and work in conjunction with the Designated Clinical Officer (DCO) for Special Educational Needs and Disabilities (SEND) to ensure compliance with statutory requirements

3.12 Safeguarding

Work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018).

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

As appropriate children's and Adult safeguarding procedures should be adhered to in all cases

3.13 Chaperone Policy

Have appropriate chaperone policies aligned to current national guidance:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

3.14 Was Not Brought Policy

Have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:

https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3.15 Access and Information

The service is offered between 8.30-4.30 Monday-Fridays; late appointments can be arranged as an exception. The service does not cover bank holidays.

The Provider will:

- Provide clear information for the Local Offer so parents and carers can access information about the occupational therapy service.
- Ensure that access to the service is equitable and timely.
- For referred children - equip parents / carers with the information they need to support the development of their child's occupational performance.
- Provide health and education staff with appropriate information to help them understand and support children's occupational performance.
- Advise and educate partners so that the environments where children spend time (within and outside the home) can be adaptive and responsive to their physical needs.

3.16 Any acceptance and exclusion criteria and thresholds

Referrals may be accepted from:

- Any health care professional working with children
- School staff

Parental consent is required for referrals and those without will not be accepted.

Before the OT service will accept a referral from education staff for a child falling in the school cohorts from reception to the end of year 6 with motor coordination difficulties, the referring setting must provide evidence that the child has completed a Motor Programme.

A parent/guardian can make a re-referral directly by telephoning the department. This referral will be accepted directly unless a significant medical change has occurred since the child was last seen by the service.

3.17 Exclusions

The service will not see children with an established generalised learning difficulty/learning disability/global development delay whose occupational performance skills are in line with their delay or where their primary diagnosis will prevent progress in their motor skills goals being achieved.

The service will not accept referrals for long term equipment/adaptations within the child's home.

The service will not accept referrals to address sensory integration therapy.

Referrals will not be accepted for upper limb splinting.

3.18 Interdependence with other services/providers

Key Relationships are:

- The child and their family

- Education staff in mainstream, special schools and early years settings
- Health Visitors and School Nurses
- Community Paediatricians and their team
- GPs and Consultants
- Social Services
- Other Allied Health Professional Services, e.g. Dieticians, Speech and Language Therapists, Physiotherapist
- Equipment service, wheelchairs and orthotics
- Voluntary Agencies

3.19 Applicable national standards

- National Service Framework for Children, Young People and Maternity Services (October 2004)
- The Children Act (1989, 2004)
- Aiming High for Disabled Children (May 2007)
- Child Health Promotion Programme (March 2008)
- Healthy Lives, Brighter Futures (Feb 2009)
- Working together to Safeguard Children (2010, 2013)
- Facing the Future: Standards for Paediatric Services (2011)
- Royal College of Paediatrics and Child Health Standards
- Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate document, (September 2010)
- Children and young people's outcomes forum – Report of the long term conditions, disability and palliative care sub group (DH 2012)
- Report of the children and young people's outcome forum (DH 2012)
- The Education Act 1996
- Health and Social Care Bill as implemented (2013)

Refer to Standard Contract.

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

College of Occupational Therapy standards and code of ethics.

Health Professions Council Code of Professional Conduct:

<http://www.hpcuk.org/aboutregistration/standards/standardsofconductperformanceandethics>

3.21 Applicable local standards

Treatment will be offered within 18 weeks of referral.

The following indicators will be reported.

- % Performance
- Non-Admitted Clock stops <18 weeks
- Total Non-Admitted Clock Stops

4.0 Applicable quality requirements and CQUIN goals

	4.1 Applicable quality requirements (See Schedule 4 Parts A-D) Refer to children's services quality requirements 4.2 Applicable CQUIN goals (See Schedule 4 Part E) 5.0 Location of Provider Premises 5.1 The Provider's Premises are located at: Children may be seen at their home, nursery, or school (mainstream and special) as best meets their needs. Clinics may also be offered from the service base, which is currently Hazel Trees, Fenton, Stoke on Trent, ST4 3NR.

Service Specification No.	CS_07
Service	Community Adult Occupational Therapy
Commissioner Lead	Sharon Cooper
Provider Lead	Adam McKeown
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

Occupational Therapy services enable patients to be as independent as possible in their everyday lives, whilst recovering from illness or adapting to disability. They also contribute to the enhancement of quality of life for those patients with a palliative or life-limiting illness. Occupational Therapists help patients increase their skills and abilities to carry out tasks in their living and working settings. They work with a variety of patients who have physical, mental, emotional, or developmental disabilities. They use many different treatments and activities to help patients develop, recuperate, or sustain their skills. They help patients improve their basic motor skills and reasoning capabilities and adjust to permanent function loss. The overall goal is to assist patients with having productive, satisfying, and independent lives.

Growth and demand for Occupational Therapists is driven largely by the increasing aging population.

North Staffordshire is likely to see a significant growth in older people, particularly those aged 75 and over. Between 2013 and 2021 North Staffordshire CCG will see:

- a small growth in the overall population (3% compared with 7% for England)
- an increase in the number of adults aged 50-64 (7% compared with a 12% growth nationally)
- an increase in the number of adults aged 65-74 (8% compared with 10% growth for England)
- a significant growth in people aged 75 and over (26% compared with 22% nationally), i.e. around an extra 5,000 people aged 75 and over by 2021.

Health and wellbeing profile for North Staffordshire Clinical Commissioning Group April 2014

In Stoke-on-Trent the projected increase in the older population is part of a continuing trend of increase in this group as life expectancy increases and more people in the city live to an older age. Projections estimate:

- There will be a 12.5% increase in the over 85 population - about 600 people in total.
- There will be nearly a 15% increase in the 65-69 population group - about 4,000 people.
- There will be smaller increases in both the 70-74 and 75-79 age groups amounting to about 1,600 people.
- In total, the projected increase in the 65+ population during the period [2011-2016] is estimated to be just under 4,000 people, an increase of about 10%.

Stoke-on-Trent Joint Strategic Needs Assessment <http://webapps.stoke.gov.uk/JSNA/Default.aspx> Accessed 03/12/2014

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	

Local defined outcomes

- Enhanced patient and carer experience, independence, satisfaction with the service received and quality of life
- Delivery of a service that enable patients and their carers to obtain information, knowledge and skills to facilitate self-care, wellbeing and to promote independence
- Responsive and timely access to a service that supports patients to proactively access the service in their place of residence
- To provide a service that is equitable for all eligible patients across North Staffordshire and Stoke on Trent
- Early detection ensuring prompt treatment and prevention
- Increased numbers of patients reporting they are able to self-manage their condition
- Patients (and carers where appropriate) report increased confidence in ability to self-care
- Encourage the self-reported positive experience from patients/carers reported via the patient survey
- Provide a source of knowledge and expertise for other healthcare professionals and the general public

3. Scope

3.1 Aims and objectives of service

The service aims to assess an individual's ability (including taking into account carer's needs and skills) to carry out activities of daily living and help to improve or retain skills. This may be through advice, education, practice and prescription of equipment as required enabling them to live as independently as possible.

- To provide high quality, safe care offering the best service user experience and value for money.
- To enable patients to function at an optimal level in order to promote independence and manage their own conditions effectively
- Encourage patients to manage their own health and increase confidence in self- management of conditions
- To provide a comprehensive assessment, evidence based and goal focused care plan for all patients engaged in the service, delivering meaningful improvements demonstrated by patient reported outcome measures.
- To provide support for patients, family and carers.
- To ensure effective demand management, including gate keeping, the management of waiting lists and waiting times, via an appropriate appointment booking system.
- To provide a proactive discharge process ensuring appropriate patients are discharged from the service with appropriate information and support packages.
To implement a strategy for identifying and reducing DNA rates, including appropriate solutions to minimize and prevent missed appointments and to reduce wasted staff time.
- To ensure the service is responsive and flexible enough to respond to changing need and demand.
- To provide a shared care approach ensuring communication and collaboration with relevant clinicians involved in the patients care.
- To ensure multi-disciplinary collaborative working with other specialist services across primary, secondary and social care.

3.2 Service description/care pathway

The service will provide specialised Occupational Therapy assessment, treatment and evaluation to clients with health needs who wish to maintain independent living in their place of residence. Clients' ability to perform activities of daily living will be evaluated and solutions to problem area/s suggested.

The service will assess clients outcomes based in the East Kent Outcome System (EKOS) at the beginning and end of each episode of care to measure patient improvement levels. The service will also measure and record client satisfaction using Eli-lite devices or other suitable method.

Therapists will plan and agree patient centred programmes of intervention to increase or maintain the functional ability of the client, enhance quality of life, reduce dependence on other agencies, avoid admission to hospital or care environments and promote a balanced lifestyle. Interventions may include rehabilitation, adaption of a client's tasks or environment, strategies to promote healthy ageing or provision of equipment. Frequency of intervention, expected outcomes and clear timescales will be communicated to clients and where appropriate their carers and/or families. Clients and their carer/families will be educated on expected functional difficulties relevant to their condition and therapy for them.

The service will assess, demonstrate and provide adaptive equipment (in line with agreed equipment list criteria) to assist the patient/carers with daily living and personal care tasks. This will include advice on home and environmental adaptations that make daily living easier and safer. Where appropriate general information may also be given on social care assessment or suppliers of equipment.

Assessments and Interventions will be provided in the most appropriate setting which is usually the patients' place of residence. This includes patients' homes, care homes and hospices.

Referrals will be received electronically or via paper and clinically triaged by the provider. Patients eligible under the inclusion criteria will be contacted by the provider either over the telephone (for urgent cases) and/or by letter and will be offered a date and time for their appointment. Referrals deemed to be incomplete or inappropriate will be returned with advice to the referrer. Where possible the referrer will be contacted promptly to obtain further information to prevent the need to return the referral.

A discharge summary outlining intervention and outcomes achieved will be sent to the clients GP within 10 working days. For patients who will receive a course of treatment / intervention (i.e. more than 2 appointments) a letter will be sent to the patients GP at the start of treatment to outline the plan, interventions to be received and patient goals. A discharge summary outlining intervention and outcomes achieved will also be sent to the clients GP within 10 working days of discharge.

The service will work to the following waiting times for people and the time waited will be measured from the date of receipt of referral:

- 2 – 5 days for patients with an urgent need as identified through clinical triage (for example to support admission avoidance, urgent equipment, end of life patients and awaiting hospital discharge)
- 20 working days for patients with a routine need identified through clinical triage

All patients requiring a follow up will be given an appointment, in line with clinical requirement for their condition.

If the service develops a waiting list / backlog which means patients are not seen within the timescales above this must be exception reported to Commissioners.

The service will operate Monday to Friday 8.30am – 4.30pm, with the exception of public holidays. The service will offer reasonable flexibility to ensure that people can be seen outside of these hours where necessary.

Providers will need to demonstrate that the service will be sufficiently flexible to meet service-user (and carer) need and demand in the service.

The provider will need to work with the commissioner towards 7 day services in line with national agendas.

3.3 Population covered

Eligible patients are those over the age of 16 who are registered with a North Staffordshire CCG or Stoke-on-Trent CCG GP.

Any person residing within the geographical boundaries of North Staffordshire or Stoke-on-Trent CCG who is not registered with a GP is also eligible.

The service will also proactively engage with children's Occupational Therapy services regarding transitions to adult services in order to provide coordinated and uninterrupted healthcare to avoid negative consequences.

The Provider will continue to provide services to patients in the Douglas MacMillan Hospice throughout the term of this contract but will work with commissioners to further understand the demand, activity and interventions provided.

The Provider is committed to working with commissioners during the specification period to explore how the service could expand its services to include nursing home residents. They will actively engage with the CCG to understand the nature of interventions, demand, impact on the current service, and best practice in other areas.

3.4 Any acceptance and exclusion criteria and thresholds

- The service will accept referrals for patients living in the community, including care homes from all health and social care professionals including hospices.

The service will no longer accept self-referrals however this will be honoured for patients who have historically been able to self-refer during the transition period.

Referrals will be accepted where Occupational Therapy assessment and intervention is expected to be beneficial for an individual in one or more of the following areas:

- Self-care activities
- Joint protection
- Fatigue management
- Activities of daily living
- Prevention of injuries and falls
- Palliative and end-of-life care
- Long term conditions where the patient has had a change in functional ability

- Complex manual handling assessment, advice and support for care home patients (in exceptional circumstances)

Referrals will not be accepted for:

- People not registered with a North Staffordshire or Stoke-on-Trent CCG GP unless either CCG is defined as the responsible commissioner in *Who Pays? Determining responsibility for payments to providers* (NHS England).

People with complex Learning Disability or Mental Health problems (this is provided under separate specifications). People with mild learning disabilities or mental health conditions with a primary physical need will be seen by the service; however where it is felt that a person's needs are severe or cannot be best met through the service they will be referred to the appropriate specialist team.

- People whose needs can only be addressed by an Occupational Therapist with highly specialist skills that the service does not possess.
- People who have been accepted onto another waiting list for Occupational Therapy Services, including Social Care, to address the same issue.
- Inpatients of community hospitals (this is provided under a separate specification for community hospitals)
- Nursing Home non complex manual handling assistance
- Self-referrals

Discharge criteria:

- When a person has reached their optimal level of normal occupation and is no longer progressing
- Patient is no longer registered with a GP practice within the North Staffordshire or Stoke-on-Trent CCG area
- Patient discharged themselves or service refused by person
- Existing OT patients will be discharged if they have not received treatment within the last 6 months
- Non-compliance with agreed treatment plan will lead to discharge after a reasonable period of time, i.e. 2 consecutive appointments
- In accordance with the providers Non-attendance Policy

3.5 Interdependence with other services/providers

The approach to delivery should be based on shared care, i.e. communication between all clinicians involved in the patients care, with appropriately skilled staff carrying out evidence based interventions, and structured around the patient journey.

The service provider will be expected to work alongside a number of other services and ensure patients move smoothly through the pathway by facilitating appropriate partnership working and onward referrals with:

- Patients and Carers
- General Practice
- Social Care Occupational Therapy
- Social Services
- Community Team Plus
- Allied Health Professionals
- Community Matrons
- District Nursing Teams
- Integrated Local Care Teams
- CCG Commissioners and clinical leads

The provider will interface seamlessly with all other services which would offer benefits to the patient.

- For current clients the service will send a suitable representative to any relevant patient case conferences, review meetings etc., called by another agency to discuss the client's progress. The agency should give the service a minimum of a week's notice. A report will be provided when attendance is not possible.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

National Institute for Health and Care Excellence www.nice.org.uk National Service Framework for Older People (DH, 2001)

<https://www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people>

National Service Framework for Long Term Conditions (DH, 2005) <https://www.gov.uk/government/publications/quality-standards-for-supporting-people-with-long-term-conditions>

The service provider has an onus of responsibility to keep up to date with clinical practice and comply with new guidance as it is published. Pathways should be amended to reflect agreed new guidance after agreement with the commissioner.

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

Health and Care Professions Council www.hcpc-uk.org

British Association of Occupational Therapists and College of Occupational Therapists <http://www.cot.co.uk>

4.3 Applicable local standards

Key Performance Indicators to be reported monthly (unless stated otherwise)

- i. 95% of urgent patients to be seen within 5 days
- ii. 95% of routine patients to be seen within 20 working days
- iii. 90% of patients reporting high level of satisfaction based on Patient Survey results across all services
- iv. 80% of discharged patients mostly or fully achieved expected EKOS outcomes as set out in care plan – Quarterly reporting

Information Requirements to be provided monthly

- i. Source of referral broken down by common categories
- ii. Number of contacts per month broken down by first appointment or follow up
- iii. Ratio of first to follow up appointments
- iv. Number of new referrals per month
- v. Reasons for referrals (common categories to be agreed with commissioners)
- vi. Number of patients discharged per month
- vii. Total number of patients on caseload
- viii. % of patients who DNA

To move towards recording and reporting for number of end of life patients on caseload per month (defined as last 12 months of life) and the total number of contacts per month for this group of patients.

5. Applicable quality requirements and CQUIN goals

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

Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

Services are usually provided to patients in their place of residence, as per section 3.2.

7. Individual Service User Placement

N/A

Service Specification No.	CS_08
Service	Community Adult Speech and Language Therapy
Commissioner Lead	Sharon Cooper
Provider Lead	Adam McKeown
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

Adult speech and language therapy can provide life-changing treatment, support and care for those who have difficulties with communication, and/or with eating, drinking and swallowing.

Clients are supported to effectively manage their difficulties, improve function and reduce the impact of their impairment on their quality of life for conditions including:

- Dysphasia (affecting language function) Dyspraxia (affecting motor speech function) Dysarthria (affecting the ability to articulate)
- Dysphagia (affecting eating, drinking and swallowing) Dysfluency (stammering)
- Dysphonia (disorders of voice affecting communication)

Difficulties can be lifelong and result from an injury or illness such as stroke or progressive neurological conditions.

Swallowing disorders can cause life-threatening problems with: breathing and choking; chest and other infections; poor nutrition and hydration; and invariably cause distress and depression.

Communication difficulties can result in low self-esteem, frustration, anxiety and depression. It can also affect social participation, employment, education and relationships.

Dysphagia

- There is evidence that the appropriate identification and management of dysphagia by speech and language therapists reduces morbidity, mortality and improves quality of life.
- Improved nutrition and hydration have an impact on physical and mental well-being.
- Persons with long-term conditions, who have transient, intermittent, persistent or progressive dysphagia often remain at risk of the complications associated with dysphagia and require the speech and language therapist to monitor and review progress over time.
- The appropriate management of dysphagia can reduce complications and length of stay in hospital
- Dysphagia affects:
 - 27% of those with COPD
 - Between 50 and 75% of nursing home residents
 - 200/100,000 UK population with Parkinson's disease
 - Between 40 and 78% of stroke patients

RCSLT Resource Manual for Commissioning and Planning Services for SLCN Dysphagia: updated 18-06-2013-minor amendments 14/07/14 http://www.rcslt.org/speech_and_language_therapy/commissioning/dysphagia_manual_072014 [accessed 18.11.14]

Communication difficulties

Acquired disorders of communication (dysphasia, dyspraxia, dysarthria, dysfluency and dysphonia) include patients with Motor Neurone Disease, Stroke, Multiple Sclerosis, Huntington's Disease, Brain Injury, Parkinson's Disease and Multiple System Atrophy.

There is evidence that the management of communication difficulties by speech and language therapists improves social communication following brain injury. Also conversation group therapy has a beneficial effect on pragmatic and quality of life.

Welch-West, P., Ferri, C., Aubut, JA., Togher, L. and Teasell, R. (August 2013) Evidence-Based Review of Moderate to Severe Acquired Brain Injury

Cognitive-Communication Treatments Post Acquired Brain Injury

http://www.abiebr.com/sites/default/files/modules/Module%207_Cognitive%20Communication%20Treatments%20Post%20Traumatic%20Brain%20Injury_V9_2013.pdf [accessed 17.02.15]

Dementia

- Difficulties with social communication is a predominant feature in dementia and can reduce access to recreation,

employment, social integration, including forming relationships and expressing personality. It has a major impact upon the quality of life. Speech and language therapists can assist by slowing the decline or reducing the impact of the communication impairment, and by supporting carers.

- Communication difficulties are associated with increased prevalence of challenging behaviour.
- Improved communication has an impact on behaviour, social skills, peer relationships and self-confidence
- There is evidence that interventions, including communication groups, altering the environment and methods of stimulation and support provided by speech and language therapists is effective in reducing decline and improving quality of life.

RCSLT Resource Manual for Commissioning and Planning Services for SLCN Dementia 2013
http://www.rcslt.org/about/docs/slc_n_resource_manual [accessed 18.11.14]

Resource manuals accessed from:

[http://www.rcslt.org/speech and language therapy/commissioning/resource manual for commissioning and planning services](http://www.rcslt.org/speech%20and%20language%20therapy/commissioning/resource%20manual%20for%20commissioning%20and%20planning%20services)
[accessed 18.11.14]

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

- Enhanced patient and carer experience, independence, satisfaction with the service received and quality of life
- Delivery of a service that enable patients and their carers to obtain information, knowledge and skills to facilitate self-care, wellbeing and to promote independence
- Responsive and timely access to a service that supports patients to proactively access the service in a location of their choice
- To provide a service that is equitable for all eligible patients across North Staffordshire and Stoke on Trent
- Early detection ensuring prompt treatment and prevention
- Increased numbers of patients reporting they are able to self-manage their condition
- Patients (and carers where appropriate) report increased confidence in ability to self-care
- Encourage the self-reported positive experience from patients/carers reported via the patient survey
- Provide a source of knowledge and expertise for other healthcare professionals and the general public

3. Scope

3.1 Aims and objectives of service

The service aims to provide assessment, diagnosis, therapy, practical advice and equipment* to ensure adults with acquired disorders of speech, language, communication and/or swallowing difficulties, are able to live and work to their maximum ability. The service also aims to support carers/ families and other colleagues to manage these conditions safely and effectively by offering education, training, supervision (for healthcare professionals) and support on a planned and ad hoc basis.

- To provide high quality, safe care offering the best service user experience and value for money.
- To provide comprehensive evidence-based assessment, diagnosis, intervention and management for people with disorders of speech, language, communication and/or swallowing difficulties.
- To enhance and maintain the quality of life and achieve the best healthcare outcomes for people with communication and swallowing dysfunction.
- To reduce secondary complications such as health risks associated with dysphagia and the risks of isolation, frustration and exclusion if communication needs are not identified and met.
- To provide an evidence based and goal focused care plan for all clients engaged in the service, delivering meaningful improvements demonstrated by user reported outcome measures.

- To ensure effective demand management, including gate keeping, the management of waiting lists and waiting times, via an appropriate appointment booking system.
- To provide a proactive discharge process ensuring appropriate patients are discharged from the service with appropriate information and support packages.
- To implement a strategy for identifying and reducing DNA rates, including appropriate solutions to minimise and prevent missed appointments and to reduce wasted staff time.
- To ensure the service is responsive and flexible enough to respond to changing need and demand.
- To provide a shared care approach ensuring communication and collaboration with relevant clinicians involved in the patients care.
- To provide training and support for carers and professionals that raises awareness and improves knowledge of communication and swallowing impairment, in order to improve outcomes for patients
- To ensure multi-disciplinary collaborative working with other specialist services across primary, secondary, community, mental health and social care.

* Discussions around funding of equipment to be undertaken regarding communication aids.

3.2 Service description/care pathway

The service will provide assessment, diagnosis, therapy, practical advice, training and equipment (in line with agreed local policies) to ensure that adults with speech, language, communication and/or swallowing difficulties and their carers/families are able to live and work according to their choice and ability by effectively managing their difficulties, improving function and reducing the impact of their impairment on their quality of life. This includes teaching alternative/compensatory strategies to clients and carers.

Therapists will agree achievable goals with clients, involving family and carers when appropriate, to increase or maintain the functional ability of the client, enhance quality of life and avoid admission to hospital or care environments. This will include frequency of intervention, expected outcomes and timescales.

The service will assess clients outcomes based on an evidenced based outcomes tool (e.g. East Kent Outcome System (EKOS)) at the beginning and end of each episode of care to measure patient improvement levels. The service will also measure and record client satisfaction using a user and patient questionnaire. A summary of these findings will be reported to Commissioners annually.

Therapists will facilitate onward referrals:

- For provision of specialist Augmentative and Assistive Communication (AAC) where appropriate
- To community dietetics services for dysphagia patients who require further nutrition support.
- To other services as appropriate

Referrals will be received electronically or via paper and clinically triaged by the provider. Adults eligible under the inclusion criteria will be contacted by the service and will be offered a choice of locations, date and time for their appointment. Referrals deemed to be incomplete or inappropriate will be discussed with the referrer via a telephone call.

A discharge summary outlining intervention and outcomes achieved will also be sent to the clients GP within 10 working days of discharge

The service will work to the following waiting times for people with speech, language, communication and/or swallowing difficulties and the time waited will be measured from the date of referral, the need will be identified through clinical triage of referral information. Triage will be undertaken based on good practice guidelines and appropriate risk management. Patients will be seen within:

- 10 working days for patients with an urgent need (e.g. patients who are at risk of choking/ inhalation of food/ inadequate nutritional intake or individuals who are at high psychosocial risk due to newly acquired communication difficulties or deteriorating communication skills
 - 40 working days for patients with a routine need

All patients requiring a follow up will be given an appointment, in line with clinical requirement for their condition.

If the service develops a waiting list / backlog which means patients are not seen within the timescales above this must be exception reported to Commissioners.

The service will operate Monday to Friday 9.00am – 5.00pm, with the exception of public holidays. The service will offer reasonable flexibility to ensure that people can be seen outside of these hours where necessary. Providers will need to demonstrate that the service will be sufficiently flexible to meet service-user (and carer) need and demand in the service. The provider will need to work with the commissioner towards 7 day services in line with national

agendas.

Population covered

Eligible patients are those over the age of 16* who are registered with a North Staffordshire CCG or Stoke-on-Trent CCG GP.

Any person residing within the geographical boundaries of North Staffordshire or Stoke-on-Trent CCG who is not registered with a GP is also eligible.

*Young people attending a special school up to the age of 19 years may be seen by the community children's Speech and Language service depending on the presenting condition and personal circumstances, adult and children's services will agree where the young person's needs can best be met in consultation with the young person and their family.

Community Adult speech and language services will proactively engage with Children's community speech and language services for children transferring to adult services. An individual transition plan between children's and adult-oriented health services must provide coordinated and uninterrupted healthcare to avoid negative consequences.

Any acceptance and exclusion criteria and thresholds

The service will accept referrals for patients from health and social care professionals. In addition referrals for people with swallowing difficulties will be accepted from Nursing and Residential Care Homes and Hospices within the CCG.

Referrals will be accepted where speech and language therapy assessment and intervention is expected to be beneficial for an individual with speech, language, communication needs and/or eating, drinking and swallowing difficulties. Adults with voice difficulties will be seen by the Speech and Language service at a number of locations across the health economy (including Acute Trust clinic settings).

Re-referrals will only be accepted for the same condition where the referrer is able to demonstrate a significant change (improvement or deterioration) in the patient's speech/language/communication or feeding or where there is a change in readiness/commitment to therapy.

Referrals will not be accepted for:

- People not registered with a North Staffordshire or Stoke-on-Trent CCG GP unless either CCG is defined as the responsible commissioner in *Who Pays? Determining responsibility for payments to providers* (NHS England).
- People with complex Learning Disability or Mental Health problems – (this is provided under a separate specification)
- Inpatients of community hospitals (this is provided under a separate specification for community hospitals)
- patients of acute hospitals (except as part of a handover of care if the patient will become the responsibility of community Speech and language service following discharge)
- Outpatients receiving Speech and Language treatment for the same condition in an acute setting.
- Forensic work
- Inpatients of private Hospitals/Hospices (and where a patient is CHC funded out of area)

Discharge criteria:

- Assessment indicates that therapy is not appropriate
- When a person is no longer progressing, has reached full resolution of their difficulty or they have reached their maximum potential
- Patient is no longer registered with a GP practice within the North Staffordshire or Stoke-on-Trent CCG area
- Patient discharges themselves or service refused by person
- Non-compliance with agreed care plan will lead to discharge after a reasonable period of time, i.e. 2 consecutive appointments,
- Existing speech and language patients will be discharged if they have not received treatment within the last 6 months.
- In accordance with the providers Non-attendance Policy.

Interdependence with other services/providers

The service provider will be expected to work alongside a number of other services and ensure patients move smoothly through the pathway by facilitating appropriate partnership working and onward referrals with:

- Patients and families/carers
- General Practice
- Community Dietetics Service
- Allied Health Professionals
- Community Matrons
- District Nursing Teams

- Integrated Local Care Teams
- Community Adult Learning Disability teams
- Social Care
- CCG Commissioners and clinical leads
- Voluntary Agencies
- Specialised commissioning leads

The provider will interface seamlessly with all other services which would offer benefits to the patient. The service will send a suitable representative to any relevant patient case conferences, review meetings etc., called by another agency to discuss the client's progress. The agency should give the service a minimum of a week's notice. A report will be provided when attendance is not possible.

The service will provide training for primary care and community healthcare professionals to improve knowledge of communication, voice and swallowing disorders and to help them identify people who will benefit from therapy.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

National Institute for Health and Care Excellence www.nice.org.uk National Service Framework for Long Term Conditions (DH, 2005)

<https://www.gov.uk/government/publications/quality-standards-for-supporting-people-with-long-term-conditions>

The service provider has an onus of responsibility to keep up to date with clinical practice and comply with new guidance as it is published. Pathways should be amended to reflect agreed new guidance after agreement with the commissioner.

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

Health and Care Professions Council www.hcpc-uk.org

Royal College of Speech and Language Therapy Communication Quality and Clinical Guidelines <http://www.rcslt.org>

Royal College of Speech and Language Therapy guidance on best practice in service organisation and provision

4.3 Applicable local standards

Key Performance Indicators to be reported monthly (unless stated otherwise):

- 90% of urgent patients seen within 10 working days of referral
- 90% of routine patients seen within 40 working days of referral
- 90% of patients referred by the ENT Consultant / Voice clinic seen within 13 weeks of referral (KPI reporting processes to be developed, data to be reported from May 2016 onwards)
- 90% of patients reporting high level of satisfaction based on Patient Survey results across all services (reported through the Trusts Quality schedule)
- 80% of discharged patients mostly or fully achieved expected EKOS Outcomes as set out in care plan

It is agreed that the service will work towards recording and reporting of the following:

- 95% of urgent patients offered an appointment which would take place within 10 working days of referral
- 95% of routine patients offered an appointment which would take place within 40 working days of referral
- These (v & vi) will be reported as KPI's within 6 months of implementation in the SALT service of the planned new Electronic Patient Record system (RiO).

Information Requests

- Number of contacts per month broken down by first appointment or follow up
- Number of new referrals per month (including source e.g. GP, ENT Consultant, Community Hospital, care home etc...)
- Number of patients discharged per month
- Number of patients waiting for over 40 working days for their first appointment
- % of patients who DNA
- To develop reporting systems to identify number of end of life patients on caseload per month (defined as last 12 months of life) and the total number of contacts per month for this group of patients.

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:

The service will be provided at various locations within the geographical boundaries of North Staffordshire and Stoke-on-Trent to ensure that patients can access care closer to home. The provider should ensure that all facilities used are Disability Discrimination Act compliant. The service will also offer domiciliary visits for patients who are housebound (unable to leave their place of residence due to physical or psychological illness). A patient's place of residence includes patients' homes, nursing and residential homes.

7. Individual Service User Placement

Service Specification No.	CS_09
Service	Stoke-on-Trent Youth Offending Service Health Provision
Commissioner Lead	Sharon Cooper
Provider Lead	Mel Watson
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

1.1 Evidence Base

Research suggests that children and young people at risk of offending or engaged in offending behaviour are also often dis-engaged from mainstream services, with a particular reference to health and education.

Children and young people known to the Youth Offending Service (YOS) often find it difficult to engage in health services due to the often chaotic nature of their lifestyle and the lack of confidence and self-esteem.

ACTIONS SPEAK LOUDER (Review of Health Care in the Community for Young People who Offend) 2006.

The report states that 'majority of children and young children who have offended, or who are likely to, having more health needs than those who have not offended. These needs span a range of physical, emotional and mental health areas and substance misuse problems, and are potentially linked to crime. They have to be recognised and addressed in order to increase the likelihood of making the lives of these children and young people better and free of crime'.

MESSAGE IN A BOTTLE (Joint Inspection of Youth Alcohol Misuse and Offending) 2010

'Many studies have shown a significant association between alcohol misuse and offending and antisocial behaviour, particularly in relation to violent offending. Although fewer children and young people appear to be drinking alcohol, those who are tend to start at a younger age and are drinking greater quantities whilst also doing this more frequently.

Concerns have therefore grown over the past few years; particularly about the health risks of this degree of alcohol misuse generally, as well as the links to antisocial behaviour, offences of violence, injuries and sexual health issues.'

HEALTHY CHILDREN, SAFER COMMUNITIES (A strategy to promote the health and well-being of children and young people in contact with the youth justice system) 2009.

'Contact with the Youth Justice System (YJS) should produce positive health outcomes for children. Early identification and attention to these needs should be considered integral to work to reduce youth crime and anti-social behavior'.

YOS CAMHS needs assessment 2013/14 identified that the following numbers of children and young people would require a service based on the CAMHS 4 Tiers:

Tier 1 – 151

Tier 2 – 150

Tier 3 – 29

Tier 4 – 4

Total actual numbers 334

There are approximately 300 children and young people who do not receive a routine health screen upon entry into the criminal justice system and yet research indicates that these young people often have a greater health need than their counterparts.

Consultation with children and young people also indicates that they would benefit from lower level intervention to prevent manifestation into crisis and acute services.

The greatest levels of needs are young people who require Tier 1 and 2 with the following interventions:

- Counselling
- Tier 2 targeted emotional and mental health support
- Speech and language therapy
- Anger management and behavioural support
- Family work
- Low level psychotherapy work incorporating cognitive behaviour therapy and counselling
- Parenting support

- Staff training
- Signposting to services
- Integration to universal services

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

- To improve mental/ physical health and well-being of young people who offend or are at risk of offending
- Assisting children and young people in making healthier life choices
- Contribution to a reduction in offending and numbers of children and young people progressing through the criminal justice system

3. Scope

3.1 Aims and objectives of service

To ensure that all children, young people and their families receive a proactive health screen as they are referred into the Youth Offending Service.

To deliver a timely and responsive service to meet the needs of children and young people who require a targeted health intervention.

3.2 Service description/care pathway

The service will ensure the provision of a Tier 1 and Tier 2 health service to include intervention. This provision will be provided for 52 weeks per year.

The service will work with children and young people at risk of offending within the criminal justice system and open to the Youth Offending Service. The service will ensure the following interventions are available to meet the needs of the children and young people;

- Counselling
 - Tier 2 targeted emotional and mental health support
 - Speech and language therapy
 - Anger management and behavioural support
 - Family work
 - Low level psychotherapy work incorporating cognitive behaviour therapy, play therapy and counselling
 - Parenting support
 - Staff training
 - Signposting to services
 - Integration to universal services
 - Advice will be provided on the promotion of 'healthy lifestyles'
 - Facilitation of Tier 3 referrals as appropriate
 - Specific behaviour therapies

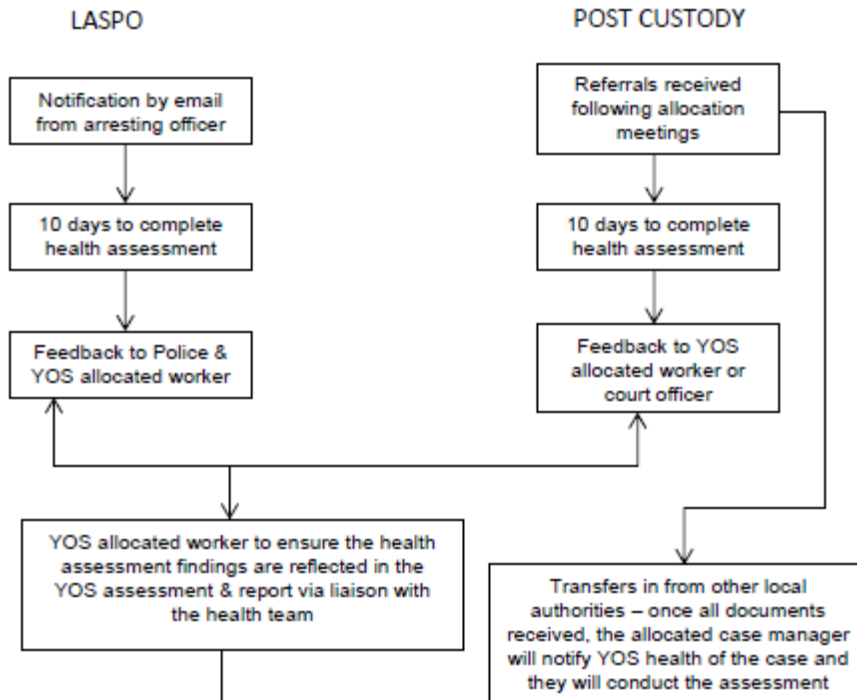
The service will provide;

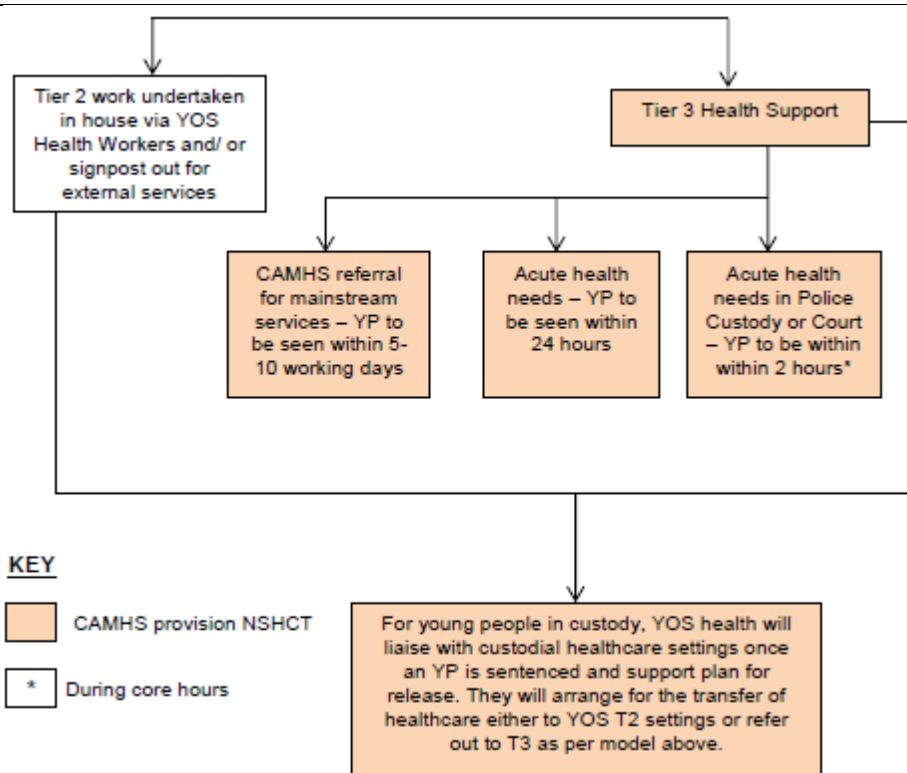
- Initial health screen (aligned to the CHAT comprehensive health assessment)
- Individual care pathways developed
- Liaison and support to YOS Case Managers
- Support and advice to parents/ carers
- Tailored interventions delivered
- Support and integration into universal health services

The lengths of intervention per service user will be needs led and dependent on the individual needs to the young person. If the need exceeds the Court Order, the provider may keep intervention open on a voluntary basis for a maximum of three months. Discharge planning will start as soon as the intervention is opened as best practice

The core service will be available Monday - Friday 08.30am – 5.00pm, however the provider will ensure that the service meets the needs of children and families and is flexible in response.

Health process for YOS young people





3.3 Population covered

The service will be available for all children and young people known to Stoke-on-Trent Youth Offending Service. Referrals will be accepted from:

3.4 Any acceptance and exclusion criteria and thresholds

The service will undertake initial screening assessments with all children and young people known to the youth offending service excluding those involved in youth liaison and diversion who will receive a service within existing contracting arrangements.

In addition, where a YOS Case Manager identifies a previously undiagnosed health need, the service will undertake a health assessment and offer intervention based on need.

All referrals will be received following management allocation meetings direct with the service on a weekly basis.

Response time and prioritisation

The service will ensure service users are contacted/ seen within 10 days of the referral, unless there is an identified acute need. Those with an acute need should be prioritised and screened and wait no longer than 5 days.

3.5 Discharge criteria and planning

Care pathways are to be developed for all children and young people referred. If the case is allocated to the service an exit strategy will be devised and discharge should be planned.

Stoke-on-Trent YOS Discharge Protocol



3.5 Interdependence with other services/providers

The service will ensure that they create and maintain relationships with partners in Education, Children and Young People's Service and voluntary sector organisations. The provider will be expected to develop and implement care pathways with other health professionals to ensure the health needs of the children and young people are met.

The service will undertake health screens with all children and young people involved with the Youth Offending Service. The service will need to be interdependent with the GP's, School, School Nurse, family and other health services.

The provider will not sub contract any element of this specification without prior consent of the Youth Offending Service. Locum and bank/ agency staff may be used to deliver the service to cover holidays and sickness absence.

3.6 Governance

Staffing levels, training, qualifications and experience

In order to deliver the service the minimum staffing levels will be 1 0.8WTE Mental Health Nurse (Band 5) and 1 0.8WTE Healthcare Assistant (Band 4) and 1 0.2 WTE Speech and Language Therapist (Band 6). The provider will ensure that all members of staff are trained to deliver work with young people and have a good understanding of the criminal justice system and the needs of offenders and their families. In addition, staff should have experience of delivering cognitive behavioral therapy in practice.

4. Applicable Service Standards

Local service standards and guidance

The service will follow local and national guidance regarding clinical governance and CQC standards. In addition the provider will work in partnership with Stoke YOS to ensure the Youth Justice Board National Standards are adhered to.

An annual programme of clinical audit is an integral part of a quality improvement programme that seeks to improve patient care and outcomes will be established. The audit programme should be developed according to the needs of the service and the specialist interests of staff. The programme will include both new audit activity and the continuation of existing audits to ensure the full audit cycle is completed.

The service is expected to demonstrate plans to support any emergencies that may arise. The provider will be required to have a quality assurance system and mechanisms to monitor and quality assure the service. For the contracted period, the provider must be able to produce accurate records for each child or young person referred into the service.

The provider will ensure communications and provision of information is coherent and followed in line with the Data Protection Act 1998 and local child and adult protection procedures, and should outline the mechanisms to safeguard information.

The provider should adhere to national and professional guidance regarding clinical governance, data protection and safeguarding.

5. Applicable quality requirements and CQUIN goals

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

6. Location of Provider Premises

The Provider's Premises are located at:

The main office is based at Liberty House, Marsdon Street, Hanley, however the service will be expected to travel to accommodate visits in secure establishments, other venues and family homes to help facilitate partner meetings.

7. Individual Service User Placement

Service Specification No.	CS_10
Service	Children & Young People Targeted Intervention Service
Commissioner Lead	Sharon Cooper
Provider Lead	Lyse Edwards
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

Health outcomes for children in England have not improved at the rate that would have been expected compared to other countries. There continues to be significant challenges taking the UK's healthcare system for children, including:

- Rising burden of non-communicable diseases
- Failure in long term condition management
- Major public health issues
- Poor outcomes of looked after children
- Safeguarding issues

According to the Joint Strategic Needs Assessment (JSNA) 2012, there were 67,000 children and young people aged 0-19 in Stoke-on-Trent, of which 584 (May 2015) attended special schools which (0.8% of the 0-19 population). The Stoke-on-Trent 2013 school census identified a special school need (SEN) school population of 8,153 (22.6%) children out of a total population of 32,062 primary, secondary and special school pupils.

This is higher in comparison to 19.4% of the school population in the West Midlands and 18.8% of the school population in England.

Stoke-on-Trent has high levels of deprivation and health inequalities, it is ranked 16th out of the 326 most deprived areas in England (IMD 2010). The city is ranked 8th worst nationally for health deprivation.

There were 170 (2013 JSNA) children and young people aged 0-19 who was registered as disabled. The majority on the register were aged 15-19 (37%) and 10-14 (36%).

The looked after children population is at its highest level, the number of looked after children has risen from March 2011 (410) to 536 in March 2014 which in part reflects the increase in referral activity and subsequent identification and intervention in respect of children in need and in need of protection.

The 2012 JSNA estimates that 10,817 children and young people have mild long standing illness and disabilities and 45 have severe disability.

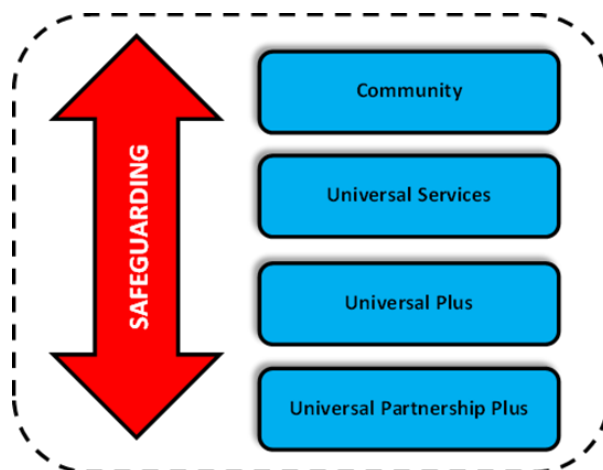
The NHS Atlas of Variation indicates that children and young people in Stoke-on-Trent in general have significantly poorer health outcomes than the national average, for examples high levels of admissions of asthma, diabetes, epilepsy and lower respiratory tract infections.

Prevalence data indicates Stoke-on-Trent has high and increasing rates of children and young people with long term conditions (120 children with diabetes, 5,780 with asthma, 220 with epilepsy, 25 with sickle cell disease, 20 with cystic fibrosis and 95 with significant physical disabilities).

In summary, Stoke-on-Trent has a significant number of children with health needs attending mainstream school and special school. It is essential that proactive advice and intervention is available to children, their families/carers and those involved in their care to ensure that they achieve the best health outcomes.

"Getting it right for children, young people and families" (Department of Health, 2012) sets out a four level model with safeguarding as a theme and responsibility through all levels. (Figure 1)

Figure 1



Community and Universal Services are the commissioning responsibility of Public Health within Local Authorities through advice and support to children, young people and their families and the delivery of the healthy child programme 5-19 years with effect from 1st April 2013.

Targeted support and intervention (universal plus and universal partnership plus) are the commissioning responsibility of Clinical Commissioning Groups (CCG's). This service specification relates solely to the CCG commissioning responsibility.

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

- Each child will have a health care plan.
- Pupils will be supported to play a full and active role in school life, remain healthy and achieve their academic potential.
- Reduction in school absence due to poor health, additional or complex health needs.
- Support children, young people and families resulting in the ability to address specific health related needs.
- Consistent approach to meeting the needs of children, young people and families with complex needs and or additional health needs.
- Enable management of conditions within a community setting, thus avoiding unnecessary secondary referrals and use urgent care services.
- Children with health needs and their families/carers/educator are supported to self-manage their condition, where appropriate, promoting independence.

3. Scope

3.1 Aims and objectives of service

Aims

- To ensure all children and young people, with a suspected or identified health needs aged 5-19 years of age (25 for those with an Education, Health and Care Plan) are offered a core programme of evidence based, regularly evaluated provision with additional early and ongoing support for those who need it.
- To provide support and health education in order to facilitate self-care and independence. This may include providing training and support around specific children and participation in sharing of skills, knowledge and expertise.

- To enable all children and young people with additional or complex health/medical needs to have access to appropriate education.

Objectives

- Deliver coordinated, needs-led, evidence based approaches or interventions that contribute to children and young people's health and wellbeing, leading to optimum health outcomes.
- Coordinate support for children and young people who have additional or complex health/ medical needs and disability. Including education and training for families, carers and educational settings.
- Where identified, support children and young people in need of early help and if appropriate, provide support to improve their life chances and prevent abuse and neglect.
- Contribute as part of a multi-agency team to the response for children, young people and families who have multiple problems.
- Provide expert advice for other professionals on a range of conditions to ensure children and young people are supported effectively in their education and home setting.
- Support the transition of children and young people with additional or complex health/medical needs and disability through their lives through a package of intervention or on an ongoing basis if required.
- The service shall provide a step up/ down model of care for CYP requiring targeted intervention (time limited); pathways will be developed to ensure safe transition and closure of cases including guidance regarding re-referral as appropriate.
- The service shall be delivered in accordance with local needs as defined by local Health and Wellbeing strategies, Children's Partnership plans, Joint Strategic Needs Assessments, Clinical Commissioning Group priorities and local insight.
- The service shall contribute to EHC assessments for CYP known to the service, this will include providing reports/ information regarding identified health needs and provision required in line with the specified timeframes.
- The service shall review EHC draft plans for which they have provided information to quality assure the accuracy of the information included in line with the specified timeframes.
- The service shall engage and work in conjunction with the Designated Clinical Officer (DCO) for Special Educational Needs and Disabilities (SEND) to ensure compliance with statutory requirements.

3.2 Service description/care pathway

The service shall deliver a targeted and specialist service through needs led targeted provision, via a referral system, working with children, young people and their families/carers/educators, who have an identified/suspected additional or complex health need and/or disability. The service shall be provided on a locality basis and will comprise appropriate skill mix to ensure the needs of all children and young people are met. The service shall be provided all year to meet the needs of the service users.. The service shall ensure it is accessible and include children and young people who are subject to school exclusion, home tutored, not in a school setting as well as Looked After Children (LAC).

In line with responsible commissioner guidance and CCG commissioning responsibilities, this service shall provide:

Universal Plus (individual/ targeted needs led)	• Coordinate support for children and young people who have complex and or additional health needs. • Assist schools with their responsibilities for managing children and young people with complex medical conditions by developing individual health care plans. • Support children and young people with long term conditions or complex health needs to facilitate appropriate management of health conditions. • Undertake continence assessments (including enuresis) and provide clinical intervention and appropriate products (excluding pads) to CYP using evidence based practice. • Contribute to the development of pathways and referrals systems to ensure that health needs are met and managed in a timely and responsive manner. • Undertake clinical interventions identified at Level 2 in line with agreed skills and competency framework (Appendix 1) • Support, undertake and coordinate where appropriate continuing care assessments for those children and young people with complex medical/ health needs that cannot be supported by commissioned universal or specialist services. • Respond to identified health need in a timely manner to minimise any potential impact on the child or young person's ability to actively participate in school like. • Provide training and support to education settings in relation to specific health conditions, to enable children with health needs and their families/carers/educator are supported to self-manage their condition, where appropriate, promoting independence. • Follow up relating to assessment and or interventions for CYP who have recently attended or been admitted to the hospital, including onward referral and partnership with other community services e.g. children's diabetes team. • Issuing of emergency contraception and support for vulnerable CYP including onward referral and signpost to other services as appropriate.	
Universal Partnership Plus (Vulnerable or Complex Families)	• Facilitate and contribute to the assessment and delivery of Education, Health and Care Plans (EHC) under the SEND reforms, working in partnership with the Designated Clinical Officer (DCO) for SEND within the CCG. • Support looked after children and Care Leavers by	
	undertaking review health assessments within statutory timescales and guidance. • To act as a proactive health advocate for looked after children ensuring their identified health needs are met. • To engage with the Independent Reviewing Officer for looked after children including contributing to the review process, where appropriate. • Act as the lead health professional (where primary need is related to health) for the Early Help assessment and intervention where health need is ongoing.	

The service shall be delivered in line with local inter-agency and internal safeguarding policies and procedures as determined by the Stoke-on-Trent Safeguarding Board. The service shall contribute to the high intensity multi-agency services for families where there are safeguarding and child protection concerns. This will be in line with 'A child-centered system. The Governments' response to the Munro review of child protection' (Department of Education, 2011) and accordance with statutory guidance 'Working Together to Safeguard Children' (HM Government 2013) where children and young people have an identified additional health need.

The service shall:

- Work jointly and in partnership with the wider local health economy safeguarding team to utilise a holistic health assessment tool for children and young people subject to a Child in Need (CIN) or Child Protection Plan (CPP) that can be used for evidence in terms of quantifying the child or young person's health needs and associated care plans.
- Be aware of children known to the service with an early help assessment, child in need, child protection or looked after child plan. To work with Designated and Named Nurses/ Doctors, providing health assessments and reports as required.
- Actively contribute to multi-agency decision making, assessments, planning and interventions relating to children in need, children at risk of harm or looked after children.
- Where the child is known to the service, the relevant lead clinician will attend child protection conferences or meetings when they are the most appropriate health lead and there is specific outcome to contribute towards.

(To attend initial and 1st review Child Protection Case Conferences).

Transition

	Mainstream School	Special School
Transition from Health Visitor	The service shall work in partnership with Health Visitors to ensure effective transition plans are in place for transfer at age 5 for CYP with special educational needs and disability or complex health needs. Planning should commence the summer prior to the child commencing school year reception.	The service shall build and maintain links with Health Visitors to ensure effective communications are in place for those CYP transferring to special schools with special education needs and disability or complex health needs so that the special school nurse can safely support the identified clinical needs of the CYP whilst in school.
Transition to adult services	For those CYP with an identified health need, the service shall ensure information is shared	The service shall develop pathways to ensure multi-disciplinary care planning
	with the GP to ensure onward referral to other services as appropriate.	processes are in place for a young person transitioning to adult services.

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years. Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments: https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3.3 Population covered

The service shall be provided in accordance with the responsible commissioner guidance to all children and young people (aged 5-19 or 25 for those with an EHC) registered with a Stoke-on-Trent GP who attend a state school, special school, independent or academy in Stoke on Trent. The service shall be flexible and delivered in the most appropriate setting dependent on the needs of the child/ young person including schools, homes, primary and other community based settings.

3.4 Any acceptance and exclusion criteria and thresholds

The service shall be provided in accordance with section 3.3. Inclusions

Referrals to the service will be accepted from the public health advisory service, schools, parents/carers, GPs, Health Visitors and Community Nursing Services, Paediatricians

Referrals will be accepted via a coordinated, centralised approach, and triaged and prioritised according to level of need; universal plus and universal partnership plus (see figure 1)

Those children and young people known to other community service such as Palliative and Complex Care Team, Continuing Care Team and Hospital at Home; this service will work in partnership to ensure a joined up approach and to minimise duplication.

Exclusions

There has to be a clear suspected or identified health need to access this service, those CYP where there needs can be met by universal services will not be eligible to access the service.

The service shall support children and young people accessing the service in a variety of settings to best meet the needs of the child, young person or family. The service shall operate a DNA/ cancellation/ non- compliance policy that following 3 failed attempts to engage the service user at which point they will be discharged and notification sent to the referring agency to ensure equitable of care for all,

3.5 Interdependence with other services/providers

The service shall work in collaboration with education/ school staff within the school to undertake tasks in accordance with the agreed matrix (Appendix 1).

The service shall link closely with others including (not exhaustive):

- **Local Authority** – safeguarding teams, Stoke-on-Trent ART, MASH, locality team and collaborative, children centres, education, children in care services, SEND services, youth offending services and public health.
- **Health** – primary care, secondary care, community services, mental health trusts.
- **Other Partners** – police, probation, schools, academies, alternative education providers, home tutors, MERIT.
- **Partnership Networks** – Safeguarding Children Boards, Stoke-on-Trent Children and Young People Partnership Board, Safeguarding Adult Board.

Regular liaison process with the following partners, where children and young people on their caseload have accessed services:

- Accident & Emergency Departments
- Children's Assessment Unit/ Wards
- General Practice
- Community Paediatricians
- Health Visiting
- Public Health Advisory Service
- Children's Community Nursing Team
- Hospital at Home
- Social Workers

- Voluntary Agencies
- Mental Health and LD services (e.g. autistic spectrum disorders)
- Allied Health Professionals

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- **The HCP from 5-19 years** (DH 2009) is a national public health programme for children and young people aged 5-19 years providing a framework setting out good practice for prevention and early intervention services for children and young people.
- **Getting it right for children, young people and families – maximising the contribution of the school nursing team: Vision and Call to Action** (DH 2012).
- **The Child and Young People's Health Outcomes Strategy** (DH 2012) identifies key themes that need addressing in order to improve health outcomes that matter most for children, young people and their families.
- **The Munro Review of Child Protection: Final Report** (2011) emphasised the importance of early help at any stage in a child or young person's life.
- **No Health without Mental Health** (2011) recognises that a good start in life and positive parenting promotes good mental health, wellbeing and resilience to adversity throughout life.
- **Children Act 1989/2004**
- **Children and Families Act 2014**
- **You're Welcome: Quality criteria for young people friendly health services** (DH 2011) sets out quality criteria to support health service commissioners and providers to improve services across 10 key themes designed to ensure services are young people friendly.
- **Working together to safeguard children** (DfE 2013)
- **Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs** (DH 2010)
- **The National Institute for Health and Clinical Excellence (NICE)** have published a range of documents relating to Child Health which can be accessed under Public Health, Child Health at <http://www.nice.org.uk>

5. Applicable quality requirements and CQUIN goals

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

5.2 Audit requirements (for the first 12 months of the service). Monthly (weekly initially) basis

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

The service shall be accessible and delivered in various locations in Stoke-on-Trent at hours and times that suit service users. This shall include non-term time cover. The service shall be accessible and delivered in schools, further education, homes, clinic settings, primary care, Children Centre's and other community venues as appropriate.

7. Individual Service User Placement

Not applicable

Service Specification No.	CS_11
Service	Home Oxygen Service - Assessment and Review
Commissioner Lead	Simon Runnett
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base

The current model of Home Oxygen Service provision is set out in the Home Oxygen Service – Assessment and Review (HOS-AR) Good Practice Guide April 2011 published by Primary Care Commissioning (the “GPG”). This was developed by a range of stakeholders including the Primary Care Respiratory Society, the British Lung Foundation, and the British Thoracic Society, the British Paediatric Respiratory Society, the Department of Health and Service User representatives.

These service specifications support the aims and objectives of the Department of Health’s Strategy for Chronic Obstructive Pulmonary Disease¹, and the Outcomes Strategy for people with COPD². They are designed to facilitate and promote systematic and good-quality service provision at suitable levels of competence throughout on an integrated basis across the care pathway and thus promote quality and productivity across the NHS.

The Department of Health figures indicate that 85,000 Service Users in England have oxygen at home at an annual cost of about £100 million. It is estimated however that between 24 and 43% of the oxygen provided is not used or delivers little or no clinical benefit. Some Service Users may be given oxygen to treat breathlessness but unless they are hypoxic, at rest or on exercise, there can be no benefit and it should not be prescribed. Waste may also result from inappropriate methods of delivery e.g. cylinders for LTOT or prescription of ambulatory devices for Service User confined to the home.

Data made available to PCT’s/CCG’s by the oxygen supply companies will identify those Service Users who currently make little or no use, or over use the oxygen they are currently prescribed. In such circumstances a specialist review is needed and where there is no evidence of clinical benefit oxygen therapy will be removed after appropriate Service User advice and counselling.

In a few instances, Service Users who have a clinical requirement for oxygen may not take advantage of the oxygen therapy prescribed for them. Where regular reviews are in place, the reasons for the under-usage can be established and overcome. In addition, potential risk from fire or explosion in the case of smokers also will be assessed by Baywater Healthcare (the home oxygen supplier). The HOS-AR is expected to liaise with Baywater Healthcare regarding risks.

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	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	x

Local defined outcomes

The expected high-level, key outcomes of the HOS-AR are:

- Increase the number of Service Users concordant with LTOT
- Increase the number of Service Users concordant with ambulatory oxygen.
- Reduction in hospital admissions.

- To ensure that users of the Service have a positive experience of care

Processes will be established to ensure that all oxygen is appropriately prescribed within the community, secondary care and by specialist paediatric teams and will be closely monitored. Protocols will be developed and training and advice provided.

3. Scope

3.1 Aims and objectives of service

The aim of the HOS-AR is

- to ensure that those prescribed home oxygen and prescribing clinicians alike should be well informed about the nature, scope and capability of the HOS-AR
- to have quality at its core and be accessible, safe, effective and responsive to Service Users
- to be evidence-based, clinically led and continually strive to improve outcomes for Service Users
- be affordable and represent good value for money
- to ensure those requiring home oxygen have an optimised treatment plan
- to withdraw Service Users who have previously been prescribed home oxygen therapy whom are not hypoxaemic or are hypoxaemic but are not compliant with their prescribed oxygen therapy

The objectives of the Service are:

- To provide easy access to assessment and follow up procedures carried out by appropriately qualified and trained healthcare professionals using appropriate diagnostic equipment.
- To provide a systematic and integrated assessment and review of Home Oxygen services
- Service quality will be improved through more effective and speedier diagnosis, leading to a higher standard of clinical treatment and improving outcomes.
- By targeting the service on those who will benefit from home oxygen, affordability and value for money will be strengthened.

3.2 Service description/care pathway

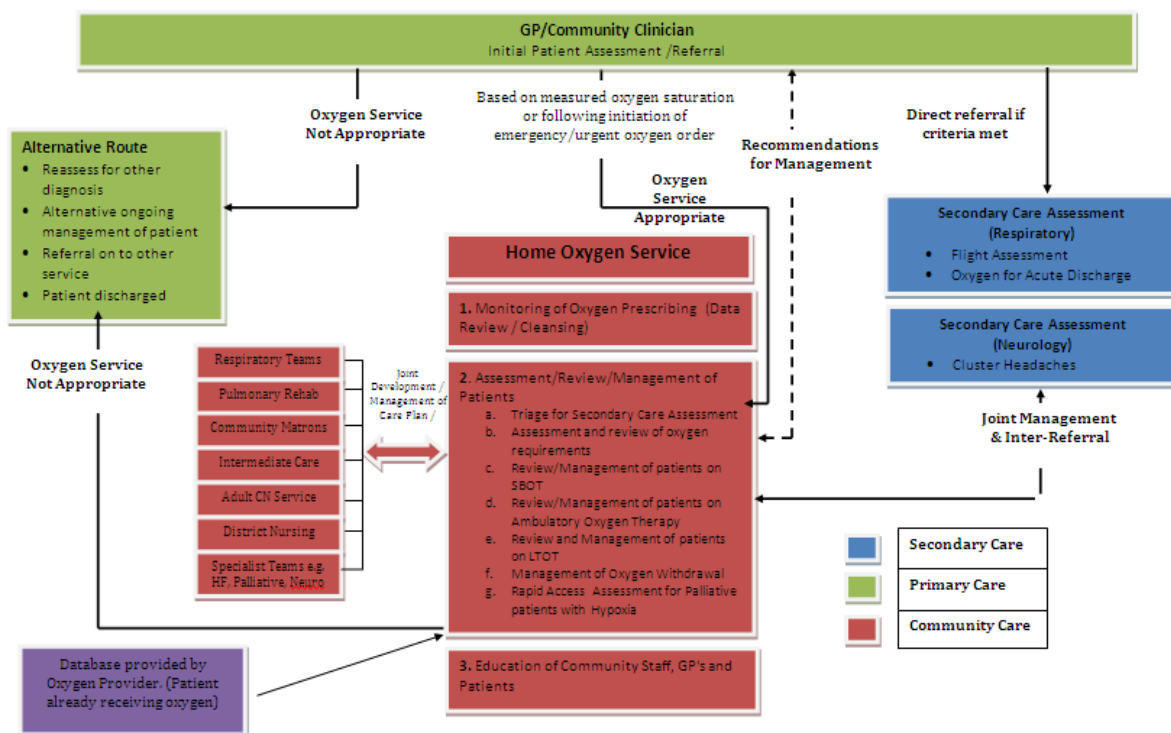
The Service will be expected to provide assessment and review for all Service Users within Stafford And Surrounds and Cannock Chase who are currently using home oxygen or are referred for a home oxygen assessment in the future.

Referrals

The referral route for Service Users requiring a home oxygen assessment in accordance with this specification are via:

- GPs
- Community Healthcare Professionals
- Specialist consultants
- Lung function department

Care Pathway



3.2.1 Home Oxygen Assessment

All referrals will be prioritised on a needs based triage. New Service Users will be offered/allocated an appointment within 3 Operational Days from receipt of referral. The provider will offer priority appointments; from receipt of referral Service User's identified as an emergency will be assessed within 1 Operational Day and Service User's identified as urgent will be assessed within 3 Operational Days.

The assessment should include quality assured diagnosis, assessment of resting and, when indicated, ambulatory oximetry.

In some instances Service User's will be in receipt of home oxygen following an acute episode. In such case Service User's will have received a Home Oxygen Assessment via Secondary Care with follow ups and on-going management to be carried out within the community HOS-AR. The HOS-AR may work in an integrated way to manage the Service User in the community. The HOS-AR must ensure robust clinical arrangements with the local acute trust to ensure a smooth efficient transfer of care.

In the absence of a designated HOS-AR previously there are approximately 884 Service User's across Stafford and Cannock whom are currently prescribed home oxygen. All Service User's currently prescribed oxygen will need to be assessed by the HOS-AR. The reviews will comply with national & local standards outlined in section 3.1 of this service specification.

Assessment for both Long Term Oxygen Therapy (LTOT) and Ambulatory Oxygen Therapy (ABOT) should be conducted by a suitably qualified and trained specialist outlined in the workforce section. Assessment should be carried out in line with current clinical guidelines.

For the avoidance of doubt, the HOS-AR shall conduct all parts of an oxygen assessment unless the Service User has complex co-morbidities such that they require being under the management of the acute sector.

If oxygen therapy is indicated, the safety, flow rate and duration of oxygen should be determined for each Service User dependent upon individual need.

In addition Service Users who make regular trips out of the home for work or leisure should complete pulmonary rehabilitation and may need further assessment for ABOT. (This does not apply to Service Users who are diagnosed with cluster headaches).

In some cases referral to social, psychological, dietary, occupational therapy or palliative care services will be required.

If at any part of the assessment stage the Service User is identified as highly complex or specialised with multiple co-morbidities or has complex delivery needs the Service User should be referred to Secondary Care for assessment if the complexities relate to respiratory. The Provider will ensure there is a robust transfer of clinical notes and will be responsible for the transfer of care. The Service User's GP must be informed of any onward referrals to a Secondary Care Respiratory service.

A risk assessment (e.g. smoking, risk of falls etc ..) needs to be undertaken

Following consultation with the Service User, the Provider shall identify the nature of the equipment/delivery system most suited to the Service User's lifestyle and condition and order this using the Home Oxygen Order Form (HOOF). Those specialists prescribing home oxygen within the HOS-AR will order oxygen using a Part B HOOF

The HOOF should be completed and sent to Baywater Healthcare and details of the plan for managing the Service User's condition should be sent to his/her GP (and referrer if different) and, where appropriate, consultant physician and home care team.

3.2.2 Assessment for LTOT

Assessment and follow up of LTOT will be in line with the NHS Primary Care Commissioning HOS-AR good practice guide

3.2.4 Assessment for Ambulatory Oxygen Therapy (ABOT)

Assessment and follow up of ABOT will be in line with the NHS Primary Care Commissioning HOS-AR good practice guide

3.2.6 Review of Short Burst Oxygen Therapy (SBOT) Definition of SBOT

Short burst oxygen therapy refers to the intermittent use of supplemental oxygen at home usually for periods of about 10 to 20 minutes at a time to relieve dyspnoea.

It is important to differentiate short burst therapy from the provision of continuous oxygen with exercise and termed ambulatory oxygen therapy or oxygen required for intermittent hypoxia (usually for acute reasons) termed intermittent oxygen therapy (IOT).

Despite extensive prescription of short burst therapy, there is no adequate evidence available to support improved clinical outcomes and it therefore **should not be used**.

Pathway (SBOT)

Most Service Users are prescribed SBOT for the treatment of breathlessness. Currently clinical evidence shows oxygen will NOT treat breathlessness in Service Users who are not hypoxic. Therefore the treatment poses an unnecessary cost to the NHS. Many Service Users have developed a psychological dependency from having SBOT available to them therefore abrupt withdrawal may cause distress. Consequently Service Users referred for SBOT assessment will be assessed by the community team following a set protocol for longitudinal measurement of oxygenation status. With the express intention of establishing if there is hypoxia which requires treatment with oxygen therapy. LTOT assessment will be conducted in those Service Users with measured chronic hypoxia and where necessary appropriate treatment prescribed.

However all Service Users without hypoxia who are on short burst oxygen therapy will be reviewed by oxygen assessment service with a view to stopping and removing the oxygen therapy. Service Users and their carers will be supported throughout this process and the joint development of an individualised care plan with existing community teams. This will support the removal unnecessary oxygen.

Priority to establish appointments will be given to the following SBOT (Data source: Baywater Healthcare invoice data) for the following areas:

- *Over / Under use of oxygen supply*
- *Multiple Orders*
- *Highlighted through Invoice Validation*

Withdrawal of oxygen therapy

The Provider will work with the Commissioners to develop an evidence based clinical protocol for the removal of home oxygen. Once the Clinical Commissioning Group's have ratified the protocol the Provider will adhere to the information within.

Where the review indicates that the Service User is no longer deriving clinical benefit from the oxygen (either because the Service User was/is not hypoxaemic or they gain no benefit from the therapy), discussion will take place about withdrawing it.

When Service Users at review are found to no longer meet the criteria for home oxygen, this should be explained, the oxygen provision discontinued and other prescribed treatments reviewed.

Where the Service User continues to meet the criteria but is not compliant with the prescribed oxygen therapy, he or she will be counselled on the merits of the therapy and encouraged to increase usage to the recommended level or a reduction in the prescribed use should be considered.

In the case of continued smoking, Service User education and expert support to stop will be offered. A risk/benefit analysis will be undertaken with medical review regarding the Service User. In some circumstances it may be appropriate to withhold or withdraw oxygen because of public safety and risk to others.

The HOS-AR will work with the Commissioners to consider the possibility of using tele-health as a means to support Service Users with withdrawal of oxygen.

The Home Oxygen Order Form (HOOF)

Baywater Healthcare are the contracted supplier of home oxygen to the West Midlands until October 2015 with a possible further two year extension. As part of the new contract commencing in October 2012 there will be two HOOFs, a Part A and a Part B. The Part A will be used by non-specialist respiratory clinicians (e.g. GPs, Consultant Neurologists). The Part B will ONLY be used by authorised specialist respiratory clinicians. The Commissioners will delegate authority to the HOS-AR Clinical Lead to authorise the use of a Part B HOOF via the consent form issued by Baywater Healthcare.

The HOS-AR will challenge prescribers raising prescriptions on a Part B HOOF that are not authorised to do so. Education regarding the process will be delivered.

The HOS-AR will ensure that all Service User's prescribed oxygen on a Part A HOOF are assessed within three months of the initial prescription. Exceptions may occur with palliative care Service Users.

A Part B HOOF will supersede all other prescriptions previously sent to Baywater Healthcare. When completing a Part B HOOF the clinician completing the HOOF will need to ensure that the prescription that is requested demonstrates the greatest value for money (i.e. considers delivery charges and number of cylinders ordered). The clinician will use the 'Mode of Supply' tool to help inform the decision. A 'Registration for Mode of Supply tool' form will need to be completed and authorised by the Commissioner for all clinicians using the tool to prescribe Part B modalities. All Part B HOOF's will need to detail the Service User's full prescription (e.g. if an amendment is made to a Service User's ABOT and they are also in receipt of LTOT, both prescriptions will need to be detailed in full). Failure to do so will result in the Service User only receiving the latest prescription detailed.

Data Review and Cleansing

Proactive monitoring and management of oxygen prescribing is critical in ensuring good compliance and is a key element of service delivery.

Evidence shows that a significant number of current Service User's make little or no use of the oxygen currently prescribed. Under-usage of oxygen therapy may arise for various reasons but most commonly Service Users are prescribed oxygen where there is no clinical benefit. By monitoring the prescribing and usage of oxygen therapy it will help to ensure that oxygen therapy is delivered only to those who will benefit clinically from it.

Data Review / Cleansing

Step 1

- Conduct a baseline evaluation into oxygen activity.
- Development and maintenance of an accurate database of all Service Users receiving home oxygen within Cannock and Stafford & Surrounds.

Step 2

- The Commissioner will forward the appropriate billing and invoice data (produced by Baywater Healthcare) to the HOS-AR. The HOS-AR will use the data to prioritise Service Users for review and raise queries with the commissioners where applicable.

Invoice validation will include:

- To query inappropriate combination orders.
- To query all multiple order where Service User has more than 3 orders.
- To ensure the Service User is in receipt of the equipment being billed for.

Monitoring of Oxygen Prescribing in the Community

Processes will be established to ensure that all oxygen is appropriately prescribed within the community and will be closely monitored. Protocols will be developed and training and advice provided.

Monitoring of Oxygen Prescribing in Secondary Care

Processes will be established to ensure that all oxygen is appropriately prescribed within the Secondary Care and will be closely monitored. Protocols will be developed and training and advice given.

Links will be made between the Secondary Care as it is their responsibility for measuring of blood gases whilst the Service User is in hospital. If it has been decided that the Service User is then discharged with ongoing oxygen at home the Service User will then be referred into the Home Oxygen team for ongoing management and monitoring.

Monitoring of Oxygen Prescribing for Children

Processes will be established to ensure that all oxygen is appropriately prescribed within by the Specialist Paediatric Teams and will be closely monitored. Protocols will be developed and training and advice given. Links will be made between these Specialist Teams and the Home Oxygen Team to ensure close monitoring of usage.

Education

Service User education will form a fundamental part of the care provided by the HOS-AR. The individual's condition, management plan and personal experience will be discussed in detail at the initial assessment.

Information leaflets, recommended sources of further information and self-care advice will be provided to every Service User. These resources will support the diagnosis and management plan and will be strengthened through the provision of telephone support where required.

Individual treatments are dependent on effective application and correct usage; therefore Service Users will be encouraged to contact the service with any queries so that these can be managed prior to considering alternative options at a follow up appointment.

Service User and carer training will cover:

- Service User's condition and reason for oxygen prescription
- principles of low flow oxygen therapy
- specific explanation of equipment choice and safe use
- back up equipment for concentrators
- explanation of the maintenance and servicing requirements of chosen equipment
- use of consumables, replacements and hygiene issues
- assessment for requirements for humidifier
 - safety check
 - dangers of smoking
 - contact numbers – HCP support
 - advice on travel with oxygen therapy
 - complaints and untoward incident management processes
 - review and follow-up processes
- Baywater Healthcare will also be providing Service User training

Clinic Letters

Following each initial assessment and all on-going formal reviews the Provider shall communicate, by way of written letter, the outcome of the appointment, including without limitation the outcome on all the above matters to the Service User, the Service User's GP and Referrer. This communication constitutes a Clinic Letter in the context of this Service Specification and shall be sent by the Provider within a maximum of 5 (five) Operational Days immediately following the Service User's appointment. The Provider shall issue letters by Royal Mail (First Class Postage) or via a secure internet based, or electronic, solution, such as NHS Net Mail, as may be directed by the Commissioner and agreed with each Referrer and Service User. In addition to the above the Provider shall ensure that each Clinic Letter, where applicable, contains:

- Clinical status
- any changes to the home oxygen prescription
- a Care Plan
- a clear description, and justification, of what further Services the Service User is being suggested for and the intended clinical outcome.
- the correct Service User's and GP's details.

The letter should also plainly state what further action the Service User's GP is being requested to undertake and the underpinning rationale, in particular where this relates to the initiation or continuation of medication prescribing.

Service User Information/Self Care

- Service User's and carers must receive information/training to cover at both assessment and reviews to include the following information:
- Reason for oxygen prescription and how it will support with management of Service User's condition
- Principles of low flow oxygen therapy
- Specific explanation of equipment choice and safe use
- Back up equipment for concentrators
- Explanation of the servicing requirements and maintenance of chosen equipment
- Use of consumables, replacements and hygiene issues
- Dangers of smoking and information for local stop smoking service
- Review and follow up processes
- Contact numbers for HOSAR/HCP support.

Information should be provided in both verbal and written form to the Service User/carer and provided in a range of different languages, appropriate to the local population. All written information should be checked by the commissioner and by appropriate Service User and public engagement groups prior to sign off.

Population covered

Population who are registered with a GP practice within the Cannock Chase or Stafford and Surrounds Clinical Commissioning Group.

Any acceptance and exclusion criteria and thresholds

The criteria of the HOS-AR are detailed below. The HOS-AR shall ensure that Service Users meet the criteria below.

Inclusion Criteria

The HOS-AR is designed to meet the needs of Service Users who might benefit from home oxygen.

Patients should have a known diagnosis before referral. It is reasonable to assume that pulse oximetry is routinely available in general practice.

The Primary Care Commissioning HOS-AR Good Practice Guide defines the criteria for referral to the HOS-AR.

Exceptions:

Service User's diagnosed with cluster headaches or other neurological conditions that have evidence to demonstrate clinical benefit with the use of home oxygen. In addition the service will assess Service Users that do not meet the home oxygen criteria for assessment but whom were prescribed home oxygen prior to October 2012.

Exclusion Criteria

- Service Users who do not meet the above criteria.
- Service Users that cannot benefit from Home Oxygen
- End of life Service Users where it is not appropriate to undertake full assessment. Although these Service Users may require support from the HOS-AR.
- Service Users under 16 years of age (as they are under specialist paediatric services and will have their own community service. The HOS-AR is expected to liaise with the relevant community team regarding compliance, education and authorisation of Part B HOOFS).

3.5 Interdependence with other services/providers

The provider must ensure that the HOS-AR is integrated with the following care providers/services in order to ensure a safe and integrated pathway approach to the Service User's care:

Community Specialist Respiratory Teams

West Midlands Ambulance Service – The HOS-AR will issue Oxygen Alert cards in line with the BTS guidance and will liaise with the West Midlands Ambulance Service to ensure alert cards can be identified in a Service User's home.

Please note: This is not an exhaustive list and others can be added to ensure the holistic needs of the Service User are met.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Home Oxygen Service – Assessment and Review Good Practice Guide April 2011 NICE
Quality standards for chronic obstructive pulmonary disease (July 2011).
18 week referral to treatment consultant led waiting times
National Service Framework for Long Term Conditions National
Carers Strategy.

N.B. This list is not exhaustive and the Provider is obligated to review evidence base on a continual basis to ensure compliance with Good Clinical Practice.

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

BTS Guidelines – Clinical Component for the home oxygen service in England and Wales 2006

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises are located at:

The Service is based at Heath Hayes Health Centre, Gorsemoor Road, Heath Hayes, Cannock, WS12 3TG.
Telephone: 01543 509756, Fax: 01543 465116. The HOS-AR will do out-reach clinics for Service Users that have difficulty travelling to Heath Hayes and will ensure that there is at least one venue in the Stafford and Surrounds area.

Location of Service Delivery

The service will offer appointments for both assessments and reviews within the clinic setting and within the domiciliary setting for those Service Users who are unable to attend the central clinic for medical reasons. It is acknowledged that it may not always be possible to perform a full LTOT assessment within a domiciliary setting therefore wherever possible patients should attend clinics. The Department of Health toolkit estimates that there will be a 20:80 split with regards to those needing a clinic in the domiciliary setting and clinic setting respectively. The North Staffordshire and Stoke Services report a 40:60 split. The Service will liaise with the Commissioners and report on the ratio split (see Information Requirements).

Days/Times of Service delivery

The opening hours, function and processes of the unit should be sufficiently flexible to accommodate future changes in service volume and to ensure that Service Users have timely access to the service, available outside the standard Operational Hours of 09:00 – 17:00 hours Monday – Friday. Therefore if Service Users are unable to attend during standard operational hours the Service would be expected to be flexible with their contracted working hours.

7. Individual Service User Placement

Not Used

Service Specification No.	CS_12
Service	Clinical Nurse Specialists in Primary Care – Adults with Learning Disabilities – Staffordshire Clinical Commissioning Groups
Commissioner Lead	Sharon Cooper
Provider Lead	Mel Watson
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base

- Transforming Care for People with Learning Disabilities Next Steps (January 2015)
- Transforming Care: A national response to Winterbourne View Hospital (Dec 2012)
- Valuing People A strategy for learning disabilities for the 21st Century (DH 2007)
- Health care For All, report of National Inquiry (2008)
- Directed Enhanced Service (2008)
- Care Quality Commission – Count me in (2009)
- Six Lives, the provision of public services to people with learning disabilities, 2009
- Equality Act (2010)
- Public Health Observatory- Health Inequalities and people with learning disabilities
- Learning Disabilities Health Observatory: The Uptake of Health Checks for adults,

People with learning disabilities experience greater health needs than others in the population and can also find access to health very challenging for a number of reasons.

The prevalence of data for people with a learning disability in England, based on the Public Health Improving Health and Lives Learning Disability Observatory was estimated in 2012 to be 1.14 million. Of these 908,000 are adults aged 18+ of whom 199,000 (22%) are known to GPs as people with a learning disability.

The local JSNA states that in Staffordshire in 2020 there is a predicted prevalence (18 – 64) of people with a learning disability of 16,467.

2. Outcomes

○ 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	

Local defined outcomes

- Reduce the overall health inequalities experienced by people with learning disabilities
- Build local capacity in mainstream and specialist health services which assist and support individuals with learning disabilities to access health services
- To have a clinical caseload of clients who are facilitated to negotiate the learning disabilities health pathways across the primary, community and acute services. The individual caseload for each CNS will be based on the individual Quality Outcomes Framework (QOF) registers for each CCG updated annually:
 - Cannock Chase
 - Stafford and Surrounds:
 - South East Staffs and Seisdon Peninsula
- To improve access for people with a learning disability registered with GP practices through a Case Management approach to primary and community health services
- Increase the uptake of GP practices offering health checks and health action plans for people with learning disabilities to at least 50% of the total number of adults with learning disability on GP registers

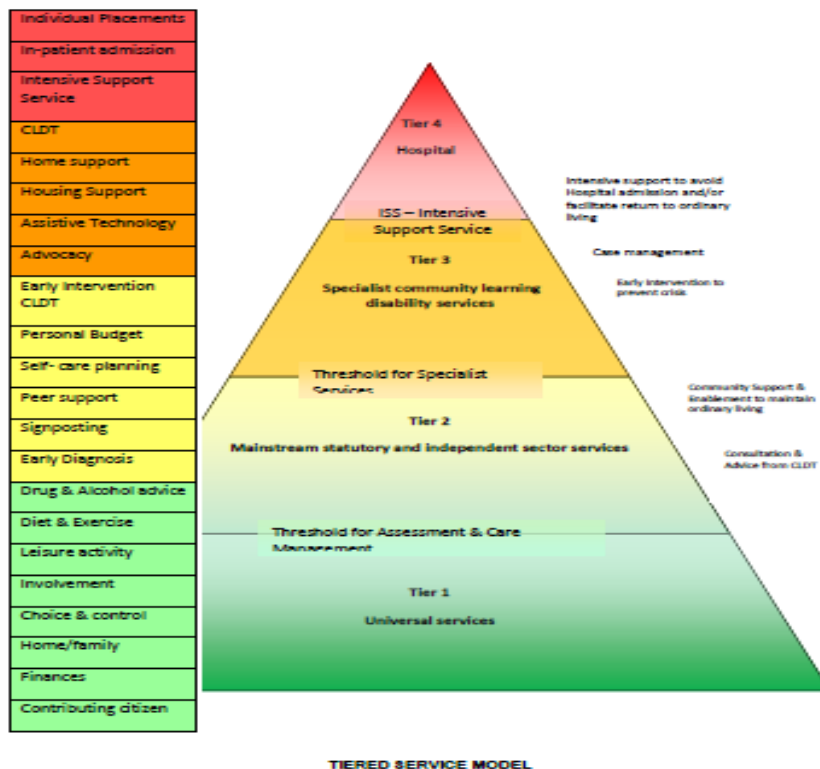
- To support GPs to provide individual Health Action Plans for people with learning disability and where appropriate improved self management of their health
- Promote better health outcomes and improve access to health promotion activities including national screening, physical activity, weight management and smoking cessation programmes
- Facilitate and support people with learning disabilities where appropriate through the acute healthcare pathways
- Improve information available for people with learning disabilities and their carers in GP practices (easy read/accessible information)
- To work with families and facilitate improved health education and health promotion activities including access to national health screening and health promotion clinics
- Supporting the Prison Health Teams in Staffordshire through providing health advice and guidance on supporting prisoners identified with a learning disability

3. Scope

3.1 Aims and objectives of service

The overall aim of the Clinical Nurse Specialists service is to reduce health inequalities by supporting people with mild, moderate or severe learning disabilities to access mainstream health care and ensure health professionals gain knowledge and skills in being able to provide primary healthcare that is responsive to their individual needs.

The Clinical Nurse Specialists Service will aim to reduce health inequalities by aligning their services to the Service Development Framework Tiered Service Model.



The Tiered Service Model provides a framework to help describe what can often be complicated needs across multiple areas of health care, and offers a way of conceptualising and mapping the health needs of people with learning disabilities. All people with learning disabilities have everyday health needs, just like anyone else. Using this tiered model, services provided at Tier 1 and 2 include primary care and mainstream health services which should be accessible to people with Learning Disabilities. Mainstream services should be able to make reasonable adjustments to allow this. Although there is a role here in Tier 1 and 2 services for specialist health learning disability teams, its role here is to support mainstream services, raise awareness of the needs of people with learning disabilities and to facilitate appropriate access. Some people with learning disabilities have additional health needs that will require more specialist assessment, treatment and support from very specialist health services, found at tier 3 and 4.

Other aims:

- To actively provide clinical case management for people with mild, moderate or severe learning disabilities in primary care:
 - - People with mild/moderate learning disabilities will usually be able to live independently with support
 - - People with severe learning disabilities are those who need significant help with daily living
- To support GP practices within Clinical Commissioning Groups (CCGs) in improving the health of people with mild, moderate or severe learning disabilities and facilitate access to mainstream health services through the appropriate channels
- To work with social care and health professionals to overcome barriers to accessing health care and develop joint

protocols as required

- To inform the commissioning and development of local services for people with learning disabilities based on relevant research
- Case manage the health needs of people with learning disabilities and their carers providing specialist advice and intervention and involving other partners where needed
- To be aware there is an unmet need and identify the significant health needs of people with mild, moderate or severe learning disabilities
- Work with partner agencies to overcome barriers to accessing mainstream health care
- Inform the commissioning and development of local learning disability health services
- To alert Commissioners to potential difficulties with provision of the service in GP practices

.2 Service description/care pathway

People with learning disabilities experience greater health needs than others in the population and can also find access to health care very challenging for a number of reasons.

The clinical case management service is provided across the Staffordshire CCGs area and offers support, education and awareness to mainstream health care providers enabling improved access to care and service delivery to patients who have a learning disability. Support is offered to primary care teams to help identify the relevant population and develop registers within primary care of people who have learning disability as well as offering advice and guidance for professionals when working with someone with a learning disability.

A clear operational focus is provided to ensure the needs of people with mild, moderate or severe learning disabilities are considered where appropriate in all aspects of the CCG and meet Equality Act (2010) and Care Quality Commission requirements.

The Clinical Nurse Specialists will:

- Carry an identified case load within each locality a number of individuals with learning disability to ensure they are accessing appropriate mainstream health services and have an appropriate package of individual support
- Facilitate the delivery and recording of annual health checks, health action plans and GP registers working with individual GP practices and Clinical Commissioning Groups including audit
- Work with health and social care colleagues in providing case management support to individuals with mild, moderate and severe needs on health action planning, access to health checks and in accessing appropriate health services
- Document assessment outcomes and information from health care plans to help commissioners identify future needs and plan for service developments
- Support people with learning disability through the admission and discharge pathways in acute care to improve quality and access
- Promote and monitor access to regular health screening and public health initiatives where appropriate and according to national guidelines eg Diabetes, CHD, Obesity health
- Ensure primary health care staff know how to find and use accessible/easy read information
- Supporting the wider primary health care community in working with people with learning disabilities eg District Nurses, Health Visitors and Allied Health Professionals
- The Clinical Nurse Specialists will each in their respective areas support primary health care services to fulfil their 'public' sector duty to demonstrate 'Reasonable Adjustments' and collect examples of good practice from primary care teams eg extended appointment times, easy read information, use of separate waiting areas, Information will be used for reporting against the Annual Learning Disabilities Health Self Assessment Framework (SAF) and to enable CCGs to monitor performance
- Development of protocols and ensure appropriate links with Community Learning Disability Health teams across Staffordshire
- Lead the work on regional and national Annual Learning Disability Health Self Assessments from a primary care perspective collating evidence and reporting on outcomes
- Report to CCG Commissioners on health developments, outcomes of clinical and quality audits, data collection and initiatives relating to people with learning disability including the production of an Annual

Report

- Ensuring the GP practice is supported to meet the needs of people with learning disabilities including an understanding of the Mental Capacity Act, promoting accessible pathways and reasonable adjustments
- CNS's will actively collect and record information using the agreed dataset within the specification (Sections 7 and 8 – Schedule 6)
- Reviewing and updating GP registers and collating information on the prevalence and health needs of people with learning disability across South Staffordshire
- Advise people with learning disability, their families and carers when there is a planned hospital admission and ensure the links are in place with the relevant acute staff
- Providing access for advice and support to Prison Healthcare staff as and when the need arises
- The team will be involved in the development and implementation of care pathways for people with learning disabilities

.3 Population covered

- South East Staffordshire and Seisdon CCG
- Stafford and Surrounds CCG
- Cannock Chase CCG

.4 Any acceptance and exclusion criteria and thresholds

- Open referral system to people with learning disabilities and their carers, health and social care professionals, as well as private care providers and those in the third sector.

Referral criteria & sources

Referrals and requests for support are in respect of adults who have a learning disability. See service criteria.

Referral route

The service has an open referral system. Access to the service will be through the following routes:

- Telephone
- Email/letters
- Direct contact with CNS
- Via other health care professionals including GPs

Exclusion

Adults without a learning disability

Response time & detail and prioritisation

Response time to requests for support are dealt with within 10 working days.

Discharge criteria and planning

Length of time of involvement will be variable with agreement from the outset.

Self-care and patient and carer information

Any plans developed will be clear and concise and in a format tailored to the person with learning disabilities' individual needs.

Interdependencies.

Case Management responsibilities for people with learning disability

- To work with Clinical Commissioning Groups to implement a the model of case management in primary care
- To act as a named lead per case that works with other stakeholders and has responsibility for recording progress and following the patient through the pathway
- There is a requirement for the CNS case manager to liaise as appropriate with the person's GP and hospital services where relevant
- Supporting people with learning disabilities to access mainstream health services

Interdependencies

• Learning Disabilities Specialist Health Providers (eg South Staffordshire and Shropshire Healthcare NHS Foundation Trust) • L/Clinical Commissioning Groups • Health and social care teams • Primary Care • Commissioners of services • User/Self advocacy groups/MENCAP • Carers • Patient Advice and Liaison Service (PALS) • Acute Care and Prison Healthcare services • Private and voluntary organisation • Prisons across Staffordshire
4. Applicable Service Standards
4.1 Applicable national standards (eg NICE) Health and Social Care Act, 2012 Equality Act, Section 149 4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges) Reasonable adjustments www.ihal.org.uk/projects/reasonable adjustments 4.3 Applicable local standards
5. Applicable quality requirements and CQUIN goals
5.1 Applicable Quality Requirements (See Schedule 4A-D) 5.2 Applicable CQUIN goals (See Schedule 4E)
6. Location of Provider Premises
The Provider's Premises are located at: Services are delivered in all districts across the CCG localities: • GP Practices/Community clinical settings • Health Trust Learning Disability services • Social care settings, • Acute Care settings, • Community hospitals, • Private and Voluntary care • Educational establishments Days/Hours of operation 9.00 -5.00 Monday- Friday
7. Individual Service User Placement
<u>Not Used</u>

Service Specification No.	CS_13
Service	Community Falls Service (SES Locality)
Commissioner Lead	Simon Runnett
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base National context

Frail older people are those who have disease or functional complaints and include issues such as finances, environment and isolation which interfere with the ability to independently perform activities of daily living.

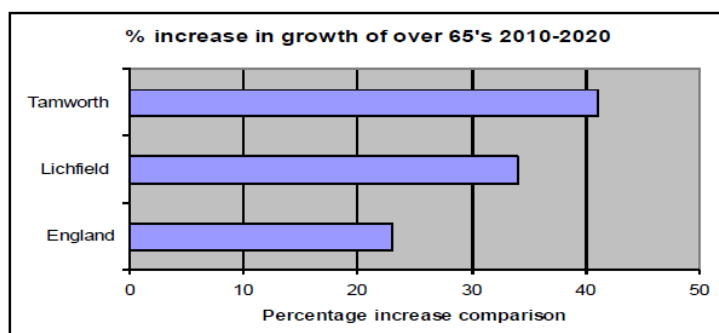
The Department of Health estimates that there are at least 15 million people who have a long term condition. Additionally, it is estimated that 57% of those are over 85 years of age are in contact with a district nurse, there will be a 31% increase in people over the age of 85 in the next ten years (*Department of Health, 2009*). The development of integrated services for frail older people is a key theme within the Health and Social Care Bill which was introduced into parliament in January 2011. Improving services, with greater emphasis on prevention, integration, better patient outcomes, system efficiency, reduced reliance on hospital based and long term care is outlined within the Health and Social Care Bill. Geriatricians are aware of the significant implications for health and social care services as the levels of disability and ill health increase and the population ages. The population of frail people in South East Staffs (SES), like much of the UK, has a complex variety of co-morbid clinical conditions.

Local context

Significant work has been completed by the South East Staffs and Seisdon Peninsula CCG (SES & SP CCG) to actively engage with our GP member practices in order to commission local and personal patient pathways that reflect the needs of our patients and the wishes of our GP referrers in the context of national, regional and local policy.

Frail older people's care is the main focus SES & SP CCG with the overall vision of having a local service to support primary, community and secondary care in the management of our increasing number of older people. In SES the population is changing. The locality has 7% of its population over 75 years of age The frail and elderly population will grow and will have a greater prevalence of those diseases that come with age.

SES & SP CCG is expecting to see a higher percentage change in the growth of people aged 65 compared to the national average (graph below) with Tamworth projected to have the most significant rise in older people 65 and over (41%)



Whilst Lichfield is expecting 34% increase in over 65 year olds Lichfield district is expecting significant pressure in the population of over 75's; projected at over 59% compared to 25% nationally (SSPCT Public Health Intelligence profiles 2010).

The impact of these projections will place an ever increasing pressure on primary, community and secondary care services. In addition to health related pressure this will also have a significant impact on social care and on early admissions to nursing and residential homes. Particular concerns have been raised regarding the care of frail older people patients within hospitals and increasingly national policy is to encourage the treatment of such patients away from hospital. Unplanned care is a leading cause of increasing healthcare costs. National and local rates of unplanned admission to hospital are on the increase. Commissioning care for frail older people is very complex as often the services patients need have historically been provided by

multiple organisations in health, social care and the third sector and draw on the skills of a number of different professional groups.

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

- Decrease in the number of patients falling numerous times; to be measured via the referral information and SUS data for fragility fractures (commissioner)
- Increase the number of patients receiving a full multifactorial assessment (Provider)
- Increase the number of patients receiving a coordinated multifactorial intervention (Provider)
- Increase the number of patients reviewed by a medical consultant (provider)
- Increase the number of staff trained in falls awareness
- Reduction in hospital admissions for mechanical falls in over 75 years of age.
- Reduction in Falls related Length of Stay of over 75's in secondary care.
- Improved patient/carer outcomes and satisfaction.
- Reduction in winter death for over 75's following a fall (in line with West Midlands)
- Service users will have access to specialist care close to home.
- Improved older adult health and better self management.
- Increased choice and independence.
- Improved knowledge and skill base for community staff.
- Improved clinical management of frail older people following a fall or those at high risk of falling . Reduction in the acute falls related expenditure.

3. Scope

Falls are a major cause of disability and the leading cause of mortality due to injury in older people. The rate for Tamworth is above the national rate. A fall can precipitate admission to long term care. After an osteoporotic fracture 50% of people can no longer live at home.

There are no recorded figures of fallers in SES locality but estimated figures are:

Patients over 65 years falling	5024-6595
Serious injuries per year	502-1648
Fractures per year	301-398

The Fall's Service in South East Staffs (SES) Locality was launched in April 2010 to achieve the desired outcomes of care closer to home, reduction in hospitalisation, improve quality outcomes for the population and to ensure people are supported to die in their chosen place of residence.

In line with CCG priorities, the current service requires development and this specification describes the intentions between SES & SP CCG and SSOTP regarding the Falls Service and the associated pathways provided through the service.

3.1 Aims and objectives of service

- To reduce the incidence of falls in SES localities population.
- To reduce the incidence of hip fractures.
- To reduce the attendance at A&E/MIUs.
- To reduce ambulance call outs to pick patients up from floor.
- To reduce attendance at GP surgeries due to falls.
- To build on pathways established.
- To build on facilitating care closer to home.

- To develop specialists assessments and treatment plans in community settings,

Objectives

- To ensure proactive assessment, treatment and care is available
- To establish community pathways for frail older people in SES locality.
- To improve services for frail older people in SES locality.
- To deliver specialists assessments and treatment plans in community settings.
- To provide education and support in primary care and to other community services.
- To establish pathways for health and social care services to deliver person centered holistic care.
- To provide education, training and support to care homes to improve their knowledge and reduce incidence of falls.

3.2 Service description/care pathway

The service will provide multifactorial assessment and appropriate interventions for patients who have fallen. The service will be a joint venture with social care providing administration to the team and exercise interventions in care home settings.

The health service component will provide:

- Occupational therapy
- Physiotherapy
- Generic support worker support
- Working in collaboration with the Community Consultants in the care of the elderly

All patients referred into the service will be triaged using an evidence based tool. Dependant on risk patients will be sent information to help them prevent further falls, have a home assessment or be seen by an appropriate consultant.

The team will provide education sessions for professionals, support staff and patients in care home settings and any other collaborative project. The service will raise the awareness of falls prevention across the locality.

Accessibility/acceptability

Majority of patients will be assessed in their own homes including care homes or be invited to attend exercise and educational groups. Any group as part of this service specification will have no extra costs applicable directly to the patient. Patients with Dementia will be able to access the service with the support of their carers.

Whole systems relationships

The service will sit with SSOTP with administration support. There will be close working relationships with GPs, commissioners, therapy services, nursing services, medical services with local acute providers, district and borough councils.

Workforce

The service provider will employ a range of staff with extensive and relevant experience to work in an integrated team delivering high quality clinical care. The workforce mix should be carefully designed in order to ensure specialisms within the team. The service provider will also employ the relevant staff to manage an effective and coordinated booking system, enabling ease of communication for referred patients.

Workforce management

The service provider will ensure that all staff participate in an annual appraisal process and achieve their continuing professional development requirements.

Workforce capacity

The service provider must ensure that they have the capacity to continue delivering the service maintaining the waiting times during periods of staff holiday, study leave, training, sickness and maternity leave.

Minimum service requirements

To carry out a multi factorial focused falls assessment on those "at high risk".
To provide analysis, management and rehabilitation to address the risk factors identified Telephone and email advice to patients and health/social care professionals.
Integrated multidisciplinary team (MDT) where care is planned and co-ordinated.

Information, data and record keeping

The service provider will have secure IT systems in place which enable the capturing of patient information and activity reporting. They will ensure that all information relating to patients is safeguarded and complies with the Data Protection Act (1998), the Access to Health Records Act (1990), the Freedom of Information Act (2000) and the Caldicott Principles. Activity reporting will be submitted by the service provider through a secure nhs.net email address.

The service provider will be responsible for keeping records secure and confidential, fully complying with the obligations contained in the CSP's Core Standards for Practice.

The service provider must understand their duties under the Freedom of Information Act and will ensure these duties are complied with.

Clinical Governance

The service provider will be responsible for their own system of clinical governance. This will include but not be limited to the following:

- Development and implementation of clinical governance policies.
- Adherence to the serious untoward incident reporting and investigation process.
- Compliance with infection control policies.
- Development and implementation of complaints policies in line with the requirements contained in the CCG policy for managing complaints and concerns.
- Use of quality assurance metrics.
- Risk management.

Equipment

The service provider shall supply all of the appropriate equipment required in the delivery of the service. The service provider will be responsible for the provision and maintenance of all equipment. If the service provider assesses that the patient needs special equipment to improve their health and wellbeing, then these will be requested from the equipment provider at no charge to the patient.

Communication

The service will ensure that all health and social care professionals including external commissioned services have access to the teams criteria and referral forms as required.

Patient information will be provided and updated to reflect changes in provision this information will be made available to patients as required. All patients will receive contact from the service either by phone or letter prior to their first appointment.

The patient will be given the following information during this communication;

- Location and time of appointment
- Contact phone number in case an appointment needs to be cancelled or rearranged
- An explanation as to what will happen in the patient's initial appointment

All service information must be produced in line with the relevant guidance contained on the NHS Identity website: <http://www.nhsidentity.nhs.uk/> and the Code of Practice for the promotion of NHS-funded services http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_083556

The service providers will also signpost and refer the patient to relevant additional services. Regular update sessions (to be held at least annually) will be arranged by the CCG to advise referring GPs about the services available, conditions that can be managed in primary care and conditions that require referral. Service providers will be asked to participate in these sessions.

Care pathway

The pathway is based on a collation of national and local evidence and best practice. It is expected that the team will work together and with partner agencies to develop this in line with best evidence. Any changes should be agreed with the commissioner

The service will consist of:

1 WTE Physiotherapist

1.04 WTE Occupational Therapist
0.4 WTE Support worker
0.6 Admin

3.3 Population covered

All Older Adults who are registered with a GP in Burntwood, Lichfield and Tamworth.
The service doesn't discriminate and will accept and review referrals for all adults over the age of 18 years who have fallen or at high risk of falls.

3.4 Any acceptance and exclusion criteria and thresholds

- All older adults at risk of falls or who have fallen

Location(s) of Service Delivery

The service will predominantly be delivered in the patients usual place of residence including care homes. Any classes and groups will be delivered in a convenient location for the majority of patients and must be easily accessible by public transport. The service provider can deliver services within the boundary of the CCG geographical area .

Days/Hours of operation Monday to Friday 9 am – 5pm

Referral criteria

Referral criteria: Any older adult registered with a GP in SES locality (Burntwood, Lichfield and Tamworth) at risk of falls or has had a fall.

Source of referral: All health and social care professionals, inclusive of but not limited to GP, WMAS, community teams, social services, care homes, nursing homes and secondary care. In addition the service will accept referrals from third sector organisations.

Referral routes

This service has a developed referral form which can be completed by any person who is concerned about a patient who has fallen or at high risk of a fall.

The referral form can be emailed, or faxed.

The service will also accept telephone referrals (WMAS) or letters.

Exclusion criteria

- **Patient who are immobile or were immobile prior to a fall**
- **Patients who refuse interventions Equal Opportunities:**

The service provider must demonstrate how they meet equal opportunity requirements in the following areas:

- They must be committed to equal opportunities and must not discriminate in performance of the service towards service users or members of staff in any way.
- The service provider must be able to provide same-sex therapists and/or chaperones at the patient's request.
- The service provider must also be able to provide premises, facilities and treatment rooms that are compliant with disability legislation.
- The service provider must be able to provide access to foreign language interpreter or sign language interpreters if necessary.
- The service provider must be able to provide written patient information in a variety of languages appropriate to the patient population in the CCG.

Response time & detail and prioritisation

- All referrals to be triaged and prioritised within 2 working days of receipt
- Prioritised according to pre-screening tool
- High priority patients to be seen 2 weeks
- Medium priority patients seen within 4 weeks
- Low risk- information to be sent to patient within 2 weeks

Discharge criteria and planning

- Patients to be discharged after assessment and time limited intervention
- Patients will be able to contact the team for further advice after an initial referral, without the need for referral from any other source

Self-care and patient and carer information

- All patients will be sent/given a copy of the Falls prevention leaflet where appropriate
- The team will monitor the usage of these leaflets and be responsible for stock control

3.5 Interdependencies

- Primary Care
- Emergency Services
- Community Providers
- Therapy teams
- Social Services
- Secondary Care wards inclusive of Hospital Discharge teams
- Voluntary Sector

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE) Compliance with relevant guidance and policy

The service must comply with the guidelines and recommendations produced by the following organisations (where applicable):

- Healthcare Commission.
- NICE Guidance and recommended pathways <http://guidance.nice.org.uk/>.
- Map of Medicine pathways provided by the NHS Institute for Innovation and Improvement <http://eng.mapofmedicine.com/evidence/map/index.html>.
- All recognised clinical service standards such as evidence based clinical guidelines from the CSP and other similar bodies.
- Applicable policies produced by SES & SP CCG and any adaptations to these policies as adopted from the 1st April 2013.
- Care Quality Commission registration requirements (when the service becomes within the scope of regulated activities requiring registration).
- Applicable National service frameworks and strategies <http://www.nhs.uk/NHSEngland/NSF/pages/nationalserviceframeworks.aspx>
- Applicable recommendations made by Robert Francis Report QA on the 6th February 2013 <http://www.midstaffspublicinquiry.com/>

The domains within published in the NHS Outcomes Framework relevant to the delivery of integrated services for older people with long term conditions include:

- Domain 2: Enhancing quality of life for people with long term condition
- Domain 4: Ensuring people have a positive experience of care.

Domain 2 is particularly relevant to the care of older people with long term conditions and the delivery of integrated care.

The NICE Quality standards likely to be relevant to the development of integrated services for older people with long term conditions include:

- Falls
- Diabetes
- Chronic Obstructive Pulmonary Disease
- COPD
- Dementia

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

- End of Life Strategy Incorporating End of Life tools (DH 2008);
- Compliance with Care Quality Commission standards and guidance;

- Compliance with NSF and NICE recommendations;
- Seven Steps to patient safety (second print 2004);
- Mental Capacity Act (DH 2005);
- Essence of Care Benchmarking ;
- Dignity Challenge (DH 2007);
- Dementia Strategy (DH 2009);
- Supporting People with Long Term Conditions DH (2005);
- Transforming Community Services DH (2009);
- The Health Act 2006: Codes of practice for the prevention and control of Health Care Associated Infections (revised 2008);
- Compliance with appropriate Health and Safety legislation (e.g. HASWA 1974 Act, COSHH, RIDDOR 1995);
- Compliance with alert notices as stipulated by the MHRA (including Equipment Evaluation Project).

4.3 Applicable local standards

As per applicable quality requirements in Schedule 4 Parts A-E

5. Applicable quality requirements and CQUIN goals

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

The CCG will monitor and evaluate the service on a regular basis through a series of methods including but not limited to service audits, service reviews, financial audit and patient feedback. The CCG will require the service provider to work with them to manage demand, reduce waiting times for patients and improve outcomes on the NHS Standard Performance Targets including the 18 week target. Achievement against monthly key performance indicators will be reported to the CCG and will be shared with referring GP Practices in order to inform their referral decisions:

- 100% of all patients referred to the service will be triaged within 2 working days of receipt of referral
- 100% of discharge letters to be sent to the referrer within 5 working days of discharge
- 10% of discharged patients to be surveyed annually with 90% of patients to be 'overall' satisfied with the service provided
- All referring practices will be sent an annually satisfaction questionnaire
- 100% of patients to be offered self care information prior to and during their treatment
- 100% of frequent fallers identified by GHH and WMAS will be reviewed appropriately, signposted or managed by the falls team. Outcomes will be reported back to the high volume user steering group.
- 100% of patients are offered education and support to reduce incidents of falls.
- 100% of care homes within SES locality will be offered education, training and support by falls team
- 100% of care homes requesting interventions from the team will receive the required input within 12 weeks Monthly outcome reports will also be required by the CCG to include, but not limited to the following indicators:
 - Source of referral
 - Number of new referrals triaged
 - Number of inappropriate referrals triaged
 - Number of initial assessments
 - Number of follow up attendances
 - Number of patients discharged
 - Number of patients requiring an onward referral to another team or provider
 - Average time to initial assessment, routine patients
 - Average time to initial assessment, urgent patients
 - Number of DNAs and cancellations
 - Number of complaints received
 - Number of Care Home contacts and the outcomes of those contacts.
 - Number of exercise classes delivered and Number of patients attending.

Quarterly outcome reports will be required by the CCG in order to monitor performance and this will include results obtained in patient satisfaction questionnaires.

The outcome report should include a summary of the results obtained and an action plan to improve outcomes for future patients.

In addition any care homes or services not engaging with the service must be highlighted to the commissioner.

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises are located at:

Within a Staffordshire and Stoke on Trent Community Facility (Currently SRP)

The premises, facilities and treatment rooms from which the service provider proposes to deliver services from must be suitable for the delivery of such a service. The provider must comply with all relevant legislation and standards including the Disabilities Discrimination Act (DDA).

The following criteria should be considered by service providers when assessing whether premises, facilities and treatment rooms are suitable:

- Location e.g. proximity to referring GP practices.
- Logistics e.g. proximity to transport networks.
- Accessibility for all patients.
- Communication services available.
- Facilities and support services.
- Dignity, respect and privacy.

7. Individual Service User Placement

Not Used

Service Specification No.	CS_14
Service	Community Falls Service (Seisdon Locality)
Commissioner Lead	Simon Runnett
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base National context

Frail older people are those who have disease or functional complaints and include issues such as finances, environment and isolation which interfere with the ability to independently perform activities of daily living.

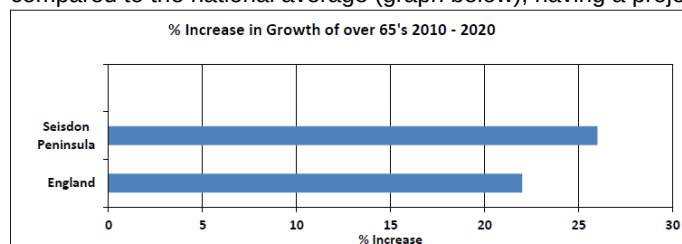
The Department of Health estimates that there are at least 15 million people who have a long term condition. Additionally, it is estimated that 57% of those are over 85 years of age are in contact with a district nurse, there will be a 31% increase in people over the age of 85 in the next ten years (*Department of Health, 2009*). The development of integrated services for frail older people is a key theme within the Health and Social Care Bill which was introduced into parliament in January 2011. Improving services, with greater emphasis on prevention, integration, better patient outcomes, system efficiency, reduced reliance on hospital based and long term care is outlined within the Health and Social Care Bill. Geriatricians are aware of the significant implications for health and social care services as the levels of disability and ill health increase and the population ages. The population of frail people in Seisdon Peninsula (SP), like much of the UK, has a complex variety of co-morbid clinical conditions.

Local context

Significant work has been completed by the South East Staffs and Seisdon Peninsula CCG (SES & SP CCG) to actively engage with our GP member practices in order to commission local and personal patient pathways that reflect the needs of our patients and the wishes of our GP referrers in the context of national, regional and local policy.

Frail older people's care is the main focus SES & SP CCG with the overall vision of having a local service to support primary, community and secondary care in the management of our increasing number of older people. In Seisdon the population is changing. The locality has 8% of its population over 75 years of age and 19% over the age of 65. The frail and elderly population will grow and will have a greater prevalence of those diseases that come with age.

Seisdon Peninsula is expecting to see a slightly higher percentage change in the growth of people aged 65 and over compared to the national average (graph below), having a projection of a 26% rise.



The impact of these projections will place an ever increasing pressure on primary, community and secondary care services. In addition to health related pressure this will also have a significant impact on social care and on early admissions to nursing and residential homes.

Particular concerns have been raised regarding the care of frail older people patients within hospitals and increasingly national policy is to encourage the treatment of such patients away from hospital.

Unplanned care is a leading cause of increasing healthcare costs. National and local rates of unplanned admission to hospital are on the increase. Commissioning care for frail older people is very complex as often the services patients need have historically been provided by multiple organisations in health, social care and the third sector and draw on the skills of a number of different professional groups.

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

- Decrease in the number of patients falling numerous times; to be measured via the referral information and SUS data for fragility fractures (commissioner).
- Increase the number of patients receiving a full multifactorial assessment (Provider).
- Increase the number of patients receiving a coordinated multifactorial intervention (Provider).
- Increase the number of patients reviewed by a medical consultant (provider).
- Increase the number of staff trained in falls awareness.
- Reduction in hospital admissions for mechanical falls in over 75 years of age.
- Reduction in Falls related Length of Stay of over 75's in secondary care.
- Improved patient/carer outcomes and satisfaction.
- Reduction in winter death for over 75's following a fall (in line with West Midlands).
- Service users will have access to specialist care close to home.
- Improved older adult health and better self-management.
- Increased choice and independence.
- Improved knowledge and skill base for community staff.
- Improved clinical management of frail older people following a fall or those at high risk of falling.
- Reduction in the acute falls related expenditure.

3. Scope

Falls are a major cause of disability and the leading cause of mortality due to injury in older people. A fall can precipitate admission to long term care. After an osteoporotic fracture 50% of people can no longer live at home.

There are no recorded figures of fallers in Seisdon locality. However, for SES locality we have estimated figures; 0.2% of the population have fractures, 0.7% have serious injuries and 3.61% of the population are patients over 65 years falling (per year). If we apply these estimates to the Seisdon locality we are able to project the following:

Patients over 65 years falling	1859
Serious injuries per year	360
Fractures per year	103

The Fall's Service in Seisdon Peninsula (SP) Locality was launched in 2009 to achieve the desired outcomes of care closer to home, reduction in hospitalisation, improve quality outcomes for the population and to ensure people are supported to die in their chosen place of residence. However, due to management changes within SSOTP this investment was absorbed into the existing CIS and the roles of the team members became generic, resulting in lack of focus on falls prevention, assessment, education and training.

In line with CCG priorities, the current service requires extraction from CIS and development as a falls only service. This specification describes the intentions between SES & SP CCG and SSOTP regarding the Falls Service and the associated pathways provided through the service.

3.1 Aims and objectives of service

Aims

- To reduce the incidence of falls in Seisdon locality population.
- To reduce the incidence of hip fractures.
- To reduce the attendance at A&E
- To reduce ambulance call outs to pick patients up from floor.
- To reduce attendance at GP surgeries due to falls.
- To build on pathways established.
- To build on facilitating care closer to home.
- To develop specialists assessments and treatment plans in community settings,

Objectives

- To ensure proactive assessment, treatment and care is available
- To establish community pathways for frail older people in Seisdon locality.
- To improve services for frail older people in Seisdon locality.
- To deliver specialists assessments and treatment plans in community settings.
- To provide education and support in primary care and to other community services.
- To establish pathways for health and social care services to deliver person centered holistic care.
- To provide education, training and support to care homes to improve their knowledge and reduce incidence of falls.

• Service description/care pathway

The service will provide multifactorial assessment and appropriate interventions for patients who have fallen, in addition offering exercise interventions in care home settings.

The health service component will provide:

- Occupational therapy
- Physiotherapy
- Generic Health Care support worker
- *Working in collaboration with the Community Consultants in the care of the elderly * this is a possible future development)

All patients referred into the service will be triaged using an evidence based tool. Dependant on risk patients will be sent information to help them prevent further falls, have a home assessment or be seen by an appropriate consultant.

The team will provide education sessions for professionals, support staff and patients in care home settings and any other collaborative project. The service will raise the awareness of falls prevention across the locality.

Accessibility/acceptability

Majority of patients will be assessed in their own homes including care homes or be invited to attend exercise and educational groups. Any group as part of this service specification will have no extra costs applicable directly to the patient.

Patients with Dementia will be able to access the service with the support of their carers.

Whole systems relationships

The service will be delivered by SSOTP who will ensure administration support is available. There will be close working relationships with GPs, commissioners, therapy services, nursing services, medical services with local acute providers, district and borough councils and care home providers.

Workforce

The service provider will employ a range of staff with extensive and relevant experience to work in an integrated team delivering high quality clinical care. The workforce mix should be carefully designed in order to ensure specialisms within the team. The service provider will also employ the relevant staff to manage an effective and coordinated booking system, enabling ease of communication for referred patients.

Workforce management

The service provider will ensure that all staff participate in an annual appraisal process and achieve their continuing professional development requirements.

Workforce capacity

The service provider must ensure that they have the capacity to continue delivering the service maintaining the waiting times during periods of staff holiday, study leave, training, sickness and maternity leave.

Minimum service requirements

To carry out a multi factorial focused falls assessment on those "at high risk".
To provide analysis, management and rehabilitation to address the risk factors identified Telephone and email advice to patients and health/social care professionals.

Integrated multidisciplinary team (MDT) where care is planned and co-ordinated.

Information, data and record keeping

The service provider will have secure IT systems in place which enable the capturing of patient information and activity reporting. They will ensure that all information relating to patients is safeguarded and complies with the Data Protection Act (1998), the Access to Health Records Act (1990), the Freedom of Information Act (2000) and the Caldicott Principles. Activity reporting will be submitted by the service provider through a secure nhs.net email address.

The service provider will be responsible for keeping records secure and confidential, fully complying with the obligations contained in the CSP's Core Standards for Practice.

The service provider must understand their duties under the Freedom of Information Act and will ensure these duties are complied with.

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The service provider will be responsible for their own system of clinical governance. This will include but not be limited to the following:

- Development and implementation of clinical governance policies.
- Adherence to the serious untoward incident reporting and investigation process.
- Compliance with infection control policies.
- Development and implementation of complaints policies in line with the requirements contained in the CCG policy for managing complaints and concerns.
- Use of quality assurance metrics.
- Risk management.

Equipment

The service provider shall supply all of the appropriate equipment required in the delivery of the service. The service provider will be responsible for the provision and maintenance of all equipment. If the service provider assesses that the patient needs special equipment to improve their health and wellbeing, then these will be requested from the equipment provider at no charge to the patient.

Communication

The service will ensure that all health and social care professionals including external commissioned services have access to the teams criteria and referral forms as required.

Patient information will be provided and updated to reflect changes in provision this information will be made available to patients as required. All patients will receive contact from the service either by phone or letter prior to their first appointment.

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- Location and time of appointment
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All service information must be produced in line with the relevant guidance contained on the NHS Identity website:

<http://www.nhsidentity.nhs.uk/> and the Code of Practice for the promotion of NHS-funded services

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Regular update sessions (to be held at least annually) will be arranged by the CCG to advise referring GPs about the services available, conditions that can be managed in primary care and conditions that require referral. Service providers will be asked to participate in these sessions.

Care pathway

The pathway is based on a collation of national and local evidence and best practice. It is expected that that the team will work together and with partner agencies to develop this in line with best evidence. Any changes should be agreed with the commissioner

Service Model

The service will consist of:

1 WTE Physiotherapist
1 WTE Occupational Therapist 1
WTE Support worker

(This will be subject to review 6 Months post Go live)

Population covered

All Older Adults who are registered with a GP in Seisdon. The service doesn't discriminate and will accept and review referrals for all adults over the age of 18 years who have fallen or at high risk of falls.

Any acceptance and exclusion criteria and thresholds

- All older adults at risk of falls or who have fallen

Location(s) of Service Delivery

The service will predominantly be delivered in the patient's usual place of residence including care homes. Any classes and groups will be delivered in a convenient location for the majority of patients and must be easily accessible by public transport.

The service provider can deliver services within the boundary of the CCG geographical area .

Days/Hours of operation Monday to Friday 9 am – 5pm

Referral criteria

Referral criteria: Any older adult registered with a GP in Seisdon locality at risk of falls or has had a fall.

Source of referral: All health and social care professionals, inclusive of but not limited to GP, WMAS, community teams, social services, care homes, nursing homes and secondary care.

In addition the service will accept referrals from third sector organisations.

Referral routes

This service has a developed referral form which can be completed by any person who is concerned about a patient who has fallen or at high risk of a fall.

The referral form can be emailed, or faxed.

The service will also accept telephone referrals (WMAS) or letters.

Exclusion criteria

- **Patient who are immobile or were immobile prior to a fall**
- **Patients who refuse interventions**

Equal Opportunities:

The service provider must demonstrate how they meet equal opportunity requirements in the following areas:

- They must be committed to equal opportunities and must not discriminate in performance of the service towards service users or members of staff in any way.
- The service provider must be able to provide same-sex therapists and/or chaperones at the patient's request.
- The service provider must also be able to provide premises, facilities and treatment rooms that are compliant with disability legislation.
- The service provider must be able to provide access to foreign language interpreter or sign language interpreters if necessary.
- The service provider must be able to provide written patient information in a variety of languages appropriate to the patient population in the CCG.

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- All referrals to be triaged and prioritised within 2 working days of receipt

- Prioritised according to pre-screening tool
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Discharge criteria and planning

- Patients to be discharged after assessment and time limited intervention
- Patients will be able to contact the team for further advice after an initial referral, without the need for referral from any other source

Self-care and patient and carer information

- All patients will be sent/given a copy of the Falls prevention leaflet where appropriate
- The team will monitor the usage of these leaflets and be responsible for stock control

3.5 Interdependencies

- Primary Care
- Emergency Services
- Community Providers
- Therapy teams
- Social Services
- Secondary Care wards inclusive of Hospital Discharge teams
- Voluntary Sector

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Compliance with relevant guidance and policy

The service must comply with the guidelines and recommendations produced by the following organisations (where applicable):

- Healthcare Commission.
- NICE Guidance and recommended pathways <http://guidance.nice.org.uk/>.
- Map of Medicine pathways provided by the NHS Institute for Innovation and Improvement <http://eng.mapofmedicine.com/evidence/map/index.html>.
- All recognised clinical service standards such as evidence based clinical guidelines from the CSP and other similar bodies.
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- Applicable recommendations made by Robert Francis Report QA on the 6th February 2013 <http://www.midstaffspublicinquiry.com/>

The domains within published in the NHS Outcomes Framework relevant to the delivery of integrated services for older people with long term conditions include:

- Domain 2: Enhancing quality of life for people with long term condition
- Domain 4: Ensuring people have a positive experience of care.

Domain 2 is particularly relevant to the care of older people with long term conditions and the delivery of integrated care.

The NICE Quality standards likely to be relevant to the development of integrated services for older people with long term conditions include:

- Falls
- Diabetes
- Chronic Obstructive Pulmonary Disease
- COPD
- Dementia

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

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- Compliance with Care Quality Commission standards and guidance;
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- Seven Steps to patient safety (second print 2004);
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- The Health Act 2006: Codes of practice for the prevention and control of Health Care Associated Infections (revised 2008);
- Compliance with appropriate Health and Safety legislation (e.g. HASWA 1974 Act, COSHH, RIDDOR 1995);
- Compliance with alert notices as stipulated by the MHRA (including Equipment Evaluation Project).

4.3 Applicable local standards

As per applicable quality requirements in Schedule 4 Parts A-E

5. Applicable quality requirements and CQUIN goals

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

Local defined key performance indicators

The CCG will monitor and evaluate the service on a regular basis through a series of methods including but not limited to service audits, service reviews, financial audit and patient feedback. The CCG will require the service provider to work with them to manage demand, reduce waiting times for patients and improve outcomes on the NHS Standard Performance Targets including the 18 week target. Achievement against monthly key performance indicators will be reported to the CCG and will be shared with referring GP Practices in order to inform their referral decisions:

- 100% of all patients referred to the service will be triaged within 2 working days of receipt of referral
- 100% of discharge letters to be sent to the referrer within 5 working days of discharge
- 10% of discharged patients to be surveyed annually with 90% of patients to be 'overall' satisfied with the service provided
- All referring practices will be sent an annually satisfaction questionnaire
- 100% of patients to be offered self-care information prior to and during their treatment
- 100% of frequent fallers identified by DGOH, New Cross and WMAS will be reviewed appropriately, signposted or managed by the falls team.
- 100% of patients are offered education and support to reduce incidents of falls.
- 100% of care homes within Seisdon locality will be offered education, training and support by fallsteam
- 100% of care homes requesting interventions from the team will receive the required input within 12 weeks
- Monthly outcome reports will also be required by the CCG to include, but not limited to the following indicators:
 - Source of referral
 - Number of new referrals triaged
 - Number of inappropriate referrals triaged
 - Number of initial assessments
 - Number of follow up attendances
 - Number of patients discharged
 - Number of patients requiring an onward referral to another team or provider
 - Average time to initial assessment, routine patients
 - Average time to initial assessment, urgent patients
 - Number of DNAs and cancellations
 - Number of complaints received
 - Number of Care Home contacts and the outcomes of those contacts.
 - Number of exercise classes delivered and Number of patients attending.

Quarterly outcome reports will be required by the CCG in order to monitor performance and this will include results obtained in patient satisfaction questionnaires.

The outcome report should include a summary of the results obtained and an action plan to improve outcomes for future patients.

In addition any care homes or services not engaging with the service must be highlighted to the commissioner.

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises are located at:

Within a Staffordshire and Stoke on Trent Community Facility (Currently Bilbrook House)

The premises, facilities and treatment rooms from which the service provider proposes to deliver services from must be suitable for the delivery of such a service. The provider must comply with all relevant legislation and standards including the Disabilities Discrimination Act (DDA).

The following criteria should be considered by service providers when assessing whether premises, facilities and treatment rooms are suitable:

- Location e.g. proximity to referring GP practices.
- Logistics e.g. proximity to transport networks.
- Accessibility for all patients.
- Communication services available.
- Facilities and support services.
- Dignity, respect and privacy.

7. Individual Service User Placement

Not Used

Service Specification No.	CS_15
Service	Community Falls Service (CC & SAS Locality)
Commissioner Lead	Simon Runnett
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base

Falls are a major cause of disability and the leading cause of mortality due to injury among older people aged over 75 in the UK. Nearly a fifth of older people who break their hips die, and of those that survive, less than one third regain their same level of mobility. Hip fractures cost UK society an estimated £726 million per annum, of which half is attributed to social care.

Falls on the stairs alone account for an estimated 1000 deaths of older people each year and a further 330,000 serious injuries. Falls are considered a major factor leading to premature admission to permanent residential care. The after effects of even the most minor fall can be catastrophic for an older person's physical and mental health. The UK population is ageing and therefore the cost of falls incurred by the NHS and other agencies is expected to escalate. Based on current trends, hip fractures among older people resulting from a fall may rise to 120,000 per annum by 2015.

There is an abundance of research into falls in the elderly population, stating that falls are a leading cause of death from injury in people over the age of 75 years, and that people over the age of 65 years suffer from at least one fall a year. The impact on the NHS in the hospitalisation and treatment of injuries associated with falls injuries is phenomenal.

People over the age of 65 years old account for 66% of all hospital admissions, and 40% of all emergency admissions.

To improve disease management and reduce avoidable falls related hospital admissions, there is a need for an effective community based falls service, to support the most appropriate management of patients in the most appropriate setting.

Factors Known to Contribute to the Risk of Falls in Elderly People Intrinsic:

- Ageing process (risk increases over 65 years)
- Poor mobility
- Cognitive impairment /confusion/agitation
- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status
- Emotional distress/depression

Extrinsic:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise
- Environmental hazards (steps, stairs, worn carpets, rugs etc.)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing/cooking etc.)

Evidence Base

- Our Health, Our Care, Our Say: A New Direction for Community Services, DoH 2006
- Department of Health (2001) The National Service Framework for Older People, Department of Health, London
- NHS Plan (2006)
- Earlier, risk managed discharge plan = reduction in "bed blocking" days (Ward 2007, RCP 2005)

- Choosing Health, DoH 2004
- The Operating Framework for the NHS in England [2012/13] (or any updated version thereof)
- Shifting Care Closer to Home Policy DoH 2008
- High Quality Care for All DoH 2009
- Codes of Professional Conduct – General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)
- The Cochrane Review - Interventions for preventing falls in elderly people 2009
- The assessment and prevention of falls in older people – NICE 2004, CG21
- Compliance with CQC Essential Standards of Quality and Safety and appropriately registered with the CQC to demonstrate this.

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

- High patient and referrer satisfaction
- Reduction in acute admissions for falls related problems
- An evidence based, structured falls education programme
- An evidenced based health promotion toolkit
- A falls winter plan
- Attendance at weekly MDT virtual ward meetings
- Improved access and choice in a community setting
- Improve education regarding the intrinsic and extrinsic contributors to falls
- Improve patient self management
- Provision of electronic patient records
- Provision of patient and carer education
- Improved clinical outcomes for patients
- Compliance with Local Quality Indicators
- Development and implementation of a bi- annual clinical audit, based on local and national priorities. This shall include an audit of 10% of cases, to ensure that they are managed in line with best clinical practice.
- Provide comprehensive data submission on a quarterly basis
- Provide prompt response to adhoc data requests
- Agree clinical outcomes to be expected from interventions

The delivery of the standards and outcomes described in this specification is the requirement to deliver a maximum 18-week referral to treatment patient pathway.

3. Scope

3.1 Aims and objectives of service

To commission evidence based, patient centred, high quality, value for money service for the prompt rehabilitation and treatment of patients who have fallen or are at risk of falling within a community setting.

Objectives

- Ensure high quality of care, by ensuring patients are treated in accordance with all relevant National guidance and that patient outcome data is collected and monitored (including patient reported outcomes as these are developed).
- Ensure sound clinical governance of services and continuing service improvement/innovation
- Ensure patients are fully informed of their condition and treatment, and that they are provided with an appropriate format of information.
- Ensure compliance with national waiting time targets and other key national and local quality and performance targets.

3.2 Service description/care pathway

The Falls Service is a community based service for the assessment and rehabilitation of patients at risk of or who have suffered a fall.

The Service shall be accessible Monday to Saturday, 8.00 am – 8.00 pm, 52 weeks per year excluding bank holidays via a single point of access.

The Service hours, function and processes of the unit(s) shall be sufficiently flexible to accommodate future changes in service volume and to ensure that patients have timely access to the service, available outside normal 9-5 hours Monday – Friday.

The Provider shall establish, maintain and proactively engage with patients and groups to ensure the timings and availability of the Services meets patients' needs. The Provider shall engage with these groups on at least a quarterly basis and demonstrate to Commissioners what action is being taken to address the concerns, or issues, raised by patients.

Appropriate treatment and diagnostics, including reviewing cardiac and neurological systems, shall be provided as required. This may require onward referral to the most appropriate health professional.

The Provider shall provide the service within the community to ensure care is delivered close to the patient's home. 25% of patients shall receive a domiciliary falls programme, however it is anticipated that this percentage may shift depending on the patient and local population needs to ensure the most effective use of resources.

The Provider shall offer each patient a choice of locations for their appointments.

The service shall deliver

- Patient choice of appointment
- Flexible appointments to support more urgent demand or unplanned care (response times)
- Relevant and timely signposting
- Face to face standard assessment with relevant investigations
- Mutually agreed and appropriate management to include individualised care bundles (treatment) and treatment plans for all patients
- Promotion and support the development of self care
- Patient information leaflets and lifestyle support
- Appropriate follow up to include review
- Communication as necessary to the patient's own GP referring clinician and after first consultation, and when adjustments are made to treatment and on discharge
- Relevant initial training and education in continence treatment to equip other healthcare workers across primary care and secondary care to access services on behalf of and for the benefit of patients
- An integrated service which can positively contribute to the local health care community and social care

Commissioners, in partnership with Primary care colleagues have considered evidenced based practice and have produced a pathway for patients at risk of or who have fallen. Providers are expected to deliver the Falls Service in line with the Care Pathway **Appendix One**. The Falls Service shall interface seamlessly with referring GPs and secondary care to ensure direct and unencumbered patient pathways.

The Provider shall deliver the following generic model

- Telephone/e-mail advice service available for GP/Primary Care queries
- Choice of day and time of appointment made by patient (or carer) with at least 2 weeks notice for non urgent patients.
- Referral clinically assessed against eligibility criteria and accepted
- Patient referred back to the referrer, if referral criteria are not met or are against commissioning policies.
- Provider to enable access to diagnostics (e.g. DEXA scans) including reviewing cardiac and neurological systems which may require onward referral to the most appropriate health professional.
- Treatment options; falls education programme, including medication review, foot care and full falls screening assessment. Treatment to be provided in line with agreed clinical protocols and NICE guidelines (where applicable) and best practice guidelines
- All referrals, to be triaged within 24 hours of referral being received.
- Telephone advice for patients

Accessibility

Service User Transport

The Provider must adhere to all Cannock Chase and Stafford & Surrounds Service Users Access Principles.

Service Users requiring transport will be subject to Service Users Transport Guidelines and will be required to meet the Service Users eligibility criteria. It is the Provider's responsibility to only offer and book transport where a Service User is unable to get to the clinic setting themselves. The responsibility for funding the cost of Service Users transport is that of Cannock Chase and Stafford & Surrounds Clinical Commissioning Groups.

The Provider will provide information about any reimbursements made to Service Users, in line with the Hospital Travel Cost Scheme (NSL Care Services working in South Staffordshire, 0333 240 0265) and recharge the Clinical Commissioning Groups accordingly.

The Provider will ensure that information provided to patients is available in suitable formats for patients with low vision.

Response time and prioritisation

All patients shall be seen as follows:

Critical and urgent patients – verbal contact made within 24 hours and assessment date offered

Non-urgent – substantive/routine – verbal contact to be made within 5 days and an appointment offered within 14 days from the date of referral. The circumstances surrounding any patient not being seen within this time period shall be reported to the Commissioner by the Provider.

The Provider shall ensure that:

1. All patients fulfilling the referral criteria referred to the Service are contacted, within 5 Operational Days of the Provider's receipt of the referral, in order to agree an appropriate time and date of appointment. For critical and urgent patients – triaged within 24 hours of referral, verbal contact shall be made on the same day as receipt of the referral. The Provider shall ensure that all patients are offered a selection of at least 3 different initial appointments and shall use its best endeavours to arrange the patient's initial appointment within 14 Operational Days of the Provider's receipt of the referral. The agreed appointment will be confirmed to the patient verbally or writing by the Provider.
2. Referrals are not rejected on the basis that the Provider has not been able to arrange an appointment with a patient in accordance with this Service Specification.
3. An appropriately qualified and competent member of the Provider's staff reviews all referrals upon receipt to ensure the appointments are offered to patients in accordance with this Service Specification and in a manner that takes account of clinical urgency and necessity.
4. Where it is deemed necessary to notify patients of their appointment then the patient shall be contacted two days prior to their appointment time, to remind the patient of this appointment. This shall be at the Provider's discretion, unless the Commissioner becomes aware of increased DNAs.

Referrals

The service shall ensure that patients are able to access services in a timely manner.

1. The Provider shall accept referrals from varying sources to include GP's, District Nurses, Community Matrons, Practice Nurses, Opticians, Secondary Care, A&E, Ambulance Service, Voluntary sector and Social Care. Self referral for review/reassessment if the patient is discharged at 6 months with open access up to 12 months post discharge.
2. Referral arrangements operated by the Provider shall be simple, streamlined and promote speedy access to services.
3. The Provider shall ensure that it markets the Service and that it provides comprehensive information about the Service it provides, including, without limitation, the referral mechanism. This information shall be sent to GPs and other potential Referrers. The Provider shall ensure that the information is up to date and circulated regularly.
4. The Provider shall accept referrals via the single point of access.
5. The Provider shall work collaboratively with the Commissioner and Referrers to improve the quality and standard of referrals to minimise inappropriate referrals and optimise the information received in referral documentation.
The Provider shall clinically assess the referral against the agreed criteria and refer the patient back to the referrer, if the criteria are not met. If the referral form is not complete, the provider must contact the referrer to obtain the information required.
6. Rejected referrals: The referrer shall be telephoned to advise of the reason for rejection for those referrals received from West Midlands Ambulance Service and A&E staff. The conversation shall be documented in the patient's notes and Lorenzo.

Assessment & Diagnosis

The service shall provide a clinically appropriate assessment of the patient using a recognised Falls Screening Tool for example; the Falls Risk Assessment Tool and shall adhere to NICE Guidelines CG21.

1. Critical and urgent referrals are verbally responded to on the same day (or next working day) and

assessment date offered.

2. Non urgent referrals are verbally responded to within 5 days of receipt of referral and appointment offered within 14 days from receipt of referral.
 - All patients meeting the referral criteria shall be offered an initial assessment (MDT /GP review where appropriate) within 2 weeks of the date of referral supported by any tests required to assist diagnosis/assessment.
 - Following assessment, the patient shall then follow the Community Falls pathway. Self care is promoted wherever clinically appropriate.

Treatment

The service shall ensure that treatments achieve the best outcomes for the patient.

Following the assessment, the Provider shall develop a Care plan for each patient and shall ensure that:

1. Informed consent to examinations and/or treatment is obtained from all patients.
2. The service environment meets the standards laid down by all National Guidance
3. The treatment is carried out in accordance with the relevant National policy and guidance .
4. Patients who require specialist treatment are referred to appropriate providers in line with local Commissioning Policies.
5. Medication reviews are initiated by the Provider and where appropriate GP to continue with prescriptions, in accordance with the Commissioners Medicines Management requirements, as provided for in the Quality Requirements.
6. Patients/carers receive adequate information
7. Self care to be promoted wherever clinically appropriate
8. Patient education to be provided, as part of assessment and education programme

Upon establishing each patients need the Provider shall provide all necessary services to the patient in accordance with this Service Specification and in respect of any activity subsequently provided to a patient shall charge the Commissioner in accordance with this Agreement. Services are to be provided at the Provider Premises and within the patient's home where appropriate.

Follow up

Aftercare and follow up are crucial to ensuring that patients experience the best possible outcome. This specification aims to ensure that patients receive suitable aftercare and follow-up, delivered in an environment to meet their needs.

- 1 Patients shall be reviewed at 6 - 12 weeks – domiciliary visits and group work 12 weeks and upto 6 months where it is identified that the individual would benefit from continued domiciliary visits.
- 2 Telephone reviews shall be used where agreed with the Commissioner and/or patient.

Care Pathways

The care pathway shall include falls assessment, medication review, foot care, education programme (where appropriate) to include but not limited to

- Physiotherapy
- Podiatry
- Occupational Therapy
- Voluntary Agencies (Age UK)
- Optician
- Pharmacist
- Diagnostics (e.g. DEXA scans, including reviewing cardiac and neurological systems) as required

Transfer and discharge from care obligations

Patients shall remain with the service for a maximum of 6 months upon which time they shall be discharged with open access up to 12 months post discharge.

Onward referrals shall be made as appropriate e.g. Social Services, Community Matron, Wheelchair Service.

If the Service rejects a referral, then the referrer shall be contacted via telephone within 2 days to advise of the reason why, particularly A&E and Ambulance Crews and the conversation documented in the patient's notes.

Written instructions and information should be given to the patient about what to do and who to contact in the event of problems or concern resulting from their treatment or care.

Arrangements for Planned Discharges

The Falls Service shall be involved with planned discharge from secondary care as requested.

On completion of treatment, the Provider shall communicate, by way of written letter/checklist review for patients, the outcome of the treatment including without limitation the outcome on all the above matters to the patient, the patient's GP and Referrer. This communication constitutes a Clinic Letter in the context of this Service Specification and shall be issued by the Provider within 2 Operational Day following the patient's discharge. The Provider shall issue letters by Royal Mail (First Class Postage) or via a secure internet based solution, such as NHS Net Mail or as may be directed by the Commissioner and agreed with each Referrer and patient. In addition to the above the Provider shall ensure that each Clinic Letter, where applicable, contains

- A diagnosis or working diagnosis
- a Care Plan, including all information that may be required by the Referrer and GP to provide ongoing care to patients.
- the correct patient's and GP's details. The letter should also plainly state what further action the patient's GP is being requested to undertake and the underpinning rationale, in particular where this relates to the initiation or continuation of medication prescribing.
- A problem header (to facilitate READ coding at GP surgeries) and record of medication.
- All changes in medication to be communicated legibly to the GP with a letter to the patient explaining that the onus is on them to request the medication (medication being restricted to those items joint formulary).
- Recommendations regarding the future management of a patient if appropriate.

Patients information/Self care

The Provider shall produce leaflets and signposting information for patients as required. This information shall be made readily available in GP practices, clinic locations and across the whole system organisations. Patients or carers can be provided with this written information if the Provider is contacted for information prior to the decision to refer.

All written patient literature shall be current and up to date with appropriate copyright acknowledgements. Print materials shall be made available in large print and alternative languages to reflect the needs of patients and always if requested. Patients and/or carers must be provided with contact numbers for the Continence Service should they require any further information or advice pre or post discharge.

3.3 Population covered

This service specification covers adults over the age of 65, resident in the geographical area of Cannock Chase and Stafford & Surrounds Clinical Commissioning Consortia. The Falls Service shall only accept referrals from patients registered with a GP within Cannock Chase and Stafford & Surrounds and meet the referral criteria. This shall also include the transient population.

3.4 Any acceptance and exclusion criteria and thresholds

The Provider shall ensure that all referrals are reviewed by appropriately skilled clinical staff to enable compliance with the Provider's obligations set out in this Service Specification.

Cannock Chase and Stafford & Surrounds Clinical Commissioning Consortia have commissioned this service and it is anticipated that referrals will only come from patients registered with a GP within these areas. Any referrals received outside these geographical areas will be rejected.

The Provider shall accept referrals received by post, fax or by secure electronic transmission.

The Provider must ensure that appropriate arrangements and systems are in place to provide a robust directly bookable Choose and Book process.

Exclusion Criteria

- Any adult under 65 years of age (NICE guidance >65 risk of falls)
- Any adults who score less than 2 on the falls screening tool
- Acute episode/exacerbation of illness that requires an acute hospital environment to deliver care needs
- Acute injury/trauma that requires an acute hospital environment to deliver care needs
- Nursing Home patients
- Amputees – to be referred onto the Amputee Clinic, MSFT
- Advanced Dementia patients; for patients scoring 10 or below on the Mini State Mental Examination (MMSE)
- Palliative patients
- Wheelchair bound
- Acute episode of self-harm
- Adults who are under the influence of alcohol/substance misuse
- Patients with a permanent impairment of the functioning of the brain as a result of a brain injury and are unable to live independently.

- Learning disability patients; those not living independently.

3.5 Interdependencies

The Provider shall work in partnership with

- Local General Practitioners (GPs)
- Diagnostic Services
- Local Acute Trusts, including specialist centres
- Local NHS Community Service providers
- Independent and Third Sector Providers
- Pharmacists
- Opticians
- Commissioning PCTs
- Local Authority Social Services Departments
- Local third sector organisations

The success of the Service shall be dependent on strong working relationships with GPs and community based professionals e.g. Intermediate Care Team and Community Intervention Service. The Provider is expected to engage with referrers through marketing the service, holding a minimum of yearly education sessions and providing feedback to referrers when referrals are rejected together with clear management plans for patients when they are discharged back to the care of the GP.

Subcontractors

Any subcontractor arrangements must be approved by Cannock Chase and Stafford & Surrounds CCGs.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE Guidance CG21, 2004 The assessment and prevention of falls in older people

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

Professional codes of conduct for staff e.g. The Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)

4.3 Applicable local standards

Any subcontractor arrangements must be approved by Commissioners.

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

7. Individual Service User Placement

Not used

Service Specification No.	CS_16
Service	Community Nursing Service (Stafford and Surrounds, Cannock Chase and Seisdon Peninsular Localities)
Commissioner Lead	Simon Runnett
Provider Lead	Adam McKeown, Midlands Partnership Foundation Trust
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

National/local context and evidence base

High quality care delivered in local communities including people's homes is embedded within national health policy. The importance of improving and extending services to meet the health and care needs of an ageing population and increasing number of service users with long term and multiple conditions is required to meet the growth in need. District nurses, as key professionals, are in a prime position to help plan, co-ordinate and provide this care.

A new vision and model for district nursing (2013, Department of Health (DoH)) to meet future health needs sets out a national strategy set within a framework of 'Compassion in Practice'. It places the values or '6Cs' of care, compassion, competence, communication, courage and commitment at the heart of district nursing service delivery. It requires new types of care which will:-

- Focus on enabling the shift in care from acute to community settings,
- Enhance the partnership between district nursing, health, social care, voluntary sector and service users to support care in people's homes (including residential care homes) and in other community settings,
- Promote and support self-care and the role of the district nurse as an enabler,
- Tackle social isolation and mental, as well as physical, health needs, especially for those that are frail and elderly,
- Promote the district nurse as a leader and case manager for complex care when it is needed and provide skilled care in acute episodes, long term conditions and at end of life.

The current evidence base for delivering nursing care is detailed below, this list, however, is not exhaustive:-

- Care In Local Communities: A new vision and model for district nursing (2013) DoH NHS Commissioning Board
- District Nursing – Harnessing the Potential (2013) Royal College of Nursing
- Delivering Care Closer To Home: Meeting the Challenge (2008) DoH

2. Outcomes

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

Local defined outcomes

- Ensure that clinical interventions support earliest return to independent living
- Support those with long term conditions to remain at home as independently as possible
- Enable patient choice of place to die at end of life; at present for Stafford & Surrounds 45% of individuals die at home (46% in hospital) and an increase of at least 5% is required. The national average is 35%.
- Reduce % of patients re-admitted to acute hospital within 30 days of discharge
- Increase service user satisfaction with the quality of nursing care and communication with the service
- Delivery of patient centred care through integrated working with health and social care providers, including

attendance at MDT meetings in primary care settings for patients on their caseload with complex care needs

- Increased awareness on the part of patients and their carers of health improvement opportunities including prevention and self-care

3. Scope

3.1 Aims and objectives of service

The Provider shall deliver a Community Nursing Service to housebound patients in their own home, with the exception of ambulatory individuals requiring complex wound care.

The definition of a housebound individual is:-

'Patients who have proven morbidity and who are genuinely unable to leave their home, either on a short term or long term basis and where there is a nursing need.' – District Nursing Referral Guidelines 2013

The definition of an ambulatory individual is:-

'Patients who are physically able (with or without assistance) to access clinic, minor injury unit or GP Practice / Walk In Centre.' – District Nursing Referral Guidelines 2013

- To deliver seamless nursing care which is proactive, integrated, innovative, well-managed and co-ordinated to support adults with a health related need through a period of transition, acute care, long-term care and palliative care.
- To improve health and wellbeing outcomes by delivering appropriate treatment whilst supporting and facilitating self-care.
- To provide generalist palliative care for service users who are suffering a life-threatening illness, cancer or non-cancer and who wish to die in their home environment.
- To provide a co-ordinated approach to discharge that facilitates a seamless transition from acute care and leads to better health outcomes.
- To promote health and wellbeing and reduce health inequalities by offering advice and information in the most appropriate way to the service user.
- To provide innovative care and services that will actively manage an anticipated year on year increase in demand.

The Service objectives are to contribute to the delivery of the vision for Stafford & Surrounds Clinical Commissioning Group (CCG); high quality healthcare services to ensure people live healthier, longer lives:-

- To provide holistic care for all adults referred to the service, ensuring shared decision making to meet individual health needs.
- To provide high quality, culturally sensitive nursing care for people in their own homes or community setting to enable service users to continue to live independently in their own home.
- To avoid unnecessary hospital admissions and facilitate early discharge from acute and short-term residential care.
- To support service user choice at end of life by fulfilling their goal of dying in their preferred place of death.
- To collect service user outcome data including Quality of Life.

To comply with national waiting targets and other key national and local quality and performance targets.

Stafford & Surrounds CCG has agreed the following principles for compliance to transform District Nursing service delivery:-

- Integrated health and social care teams.
- A proactive approach that is responsive and innovative, providing advice on assistive technologies such as telehealth and telecare.
- Application of lean philosophy to deliver productivity gains underpinned by efficiency and effectiveness in operational management, enabled through remote working and technology.
- Escalation and de-escalation of service users, within the model of care, to provide the right care, by the right health professional, at the right time.
- Fostering a culture of continuous service improvement.

3.2 Service description/care pathway

The Provider shall provide nursing care, through identified packages of nursing care, for housebound adults who have short term needs, long term conditions, complex needs from multiple conditions, or require palliative care and end of life care. Where a patient becomes ambulant during the course of their nursing care, the service shall continue to deliver care in accordance with an agreed Estimated Discharge Date with the District Nursing service to another provider, if

required.

The Provider shall work in partnership with individuals, families, carers, primary care teams, acute and social care, mental health teams and specialist nurses, independent and voluntary sectors, providing a range of interventions and services to assist service users to maximise their quality of life, promote independence and improve their health.

The Provider shall comply with the new model of 'Care in local communities, *A new vision and model for district nursing* (DH, 2013) to meet the health needs of the population. This shall be achieved through the District Nursing Service providing care and support in the community, including peoples' homes, that encompasses three core elements of population and caseload management, support and care for service users who are unwell, recovering at home and at end of life and support and care for independence.

Core Elements

A comprehensive initial assessment* of service users accepted by the service, including:-

- The agreement of personal goals/outcomes,
- The creation of an individual care plan which determines the best environment for the delivery of the nursing care package; the service user's home (temporarily or permanently housebound), or in a community setting (eg, wherein the service user becomes ambulant during the delivery of a package of nursing care, or in cases where the practitioner has determined that the service user is fit to attend a community clinic setting for services such as wound care),
- Appropriate onward referral to specialist services following assessment, where appropriate, eg, the Multi-Factorial Risk Assessment (FRAT) to the Falls Prevention Team, the Malnutrition Universal Screening Tool (MUST) to community dieticians, pain tool to the chronic pain team.

* It is recognised that a comprehensive assessment may not be needed for all service users dependent upon the nursing task to be delivered.

Ongoing assessments shall include daily monitoring and treatment based on the professional's clinical judgment for:-

- Continence to include residential home patients
- Falls – Level 1 falls assessment to support the delivery of the local Falls strategy,
- Long term conditions as required as part of the service user's ongoing package of care for individuals that are housebound, or find it difficult to access regular healthcare
- Palliative care and end of life service users.

Identification and acknowledgement of carer needs using assessment tools which form part of the care management process, where appropriate, signposting carers to suitable alternative support services, including social care and third sector services.

Clinical Tasks

- Public health services, including participation in immunisation programmes for older people, eg, influenza and those with long term conditions on the nursing caseload,
- Advice / guidance for individuals and families during treatments and life changing events, eg, amputation, mastectomy as part of immediate post-surgery care, bereavement,
- Provision of pain management and symptom control for terminally ill service users, delivery of End of Life care which supports and ensures the use of End of Life tools including advanced care plans and, where appropriate, ensuring referral and access to Specialist Palliative Care (SPC) services, third sector and other relevant community based services for service users/carers at End of Life,
- Care and management of tracheotomies – short term intervention to support patients, families and carers with self-management and wound care
- Verification of death (out of hours for nursing caseload),
- Phlebotomy – venepuncture for service users at home and in residential settings where there is regular and ongoing District Nurse intervention that requires phlebotomy as part of a service user's package of nursing care,
- Simple and complex wound care,
- Pressure ulcer prevention and management for patients,
- Ear syringing,
- Performing catheterisation,
- Trial without catheter (TWOC)
- Continence – assessment for provision of continence supplies and referral to specialist continence services, support for those with dwelling catheters and catheter care (care of urethral/supra-pubic

- catheters),
- Supporting bowel management pathways,
- Management of PleurX chest and breast drains,
- Management of diabetes,
- Doppler assessments (see attached criteria),,
- Medication management including the administration of medication,
- Nurse formulary and non-medical prescribing against a clearly defined formulary,
- Continuing Health Care – brokering packages of care for service users at the end of their life.

To maintain wellness and support health improvement to the best possible level, to ensure that service users and their carers are appropriately informed, involved and supported to promote their role in the safe delivery of their care, including self-care.

Long Term Conditions Multi-Disciplinary Team Meetings – an appropriate member of the nursing team may be required to attend a Multi-Disciplinary Team for service users that are part of the active caseload.

Rehabilitation/Reablement – the Service shall link with other providers to support efficient and seamless service user journeys.

Access to intermediate care beds – where appropriate, Stafford & Surrounds service users shall be referred to Intermediate Care beds within the wider health locality, when referred via the Single Point of Access.

Advance Care Plan – the teams will take an active role in advance care planning for palliative and end of life patients, this will support patient choice around preferred place of care.

Neighbourhood Model – teams shall be aligned to geographical areas in Neighbourhoods: North (Trentside), Central (Rising Brook) and South (Weeping Cross) with each GP practice being kept advised of which District Nurse is the allocated key worker for each patient together with a suitable alternative contact in the key worker's absence.

Hours of Operation – provision to be 0800 to 1830 hours with Out of Hours 1830 to 0800 hours, 7 days per week, 365 days per year, via a Single Point of Access to each team and interface with the Intermediate Care Team for seamless service transition for service users. Service provision must be planned around patient need and demand

Discharge Arrangements

Upon completion of the package of care, or where regular review is not required, usually due to the achievement of medical stability, the service user shall be discharged from the caseload to self-care or normal management plan.

Service users that move out of the area shall be transferred to their subsequent health provider by the Provider.

Where appropriate, discharge planning shall be discussed from the day of admission to the nursing caseload. The service user shall have a clear plan and expected outcomes with predicted timeframes, if possible, and review date(s).

When a service user is transferred to another provider service a summary of the assessment and care given shall accompany the service user and the service user's General Practitioner shall be advised by the key worker/service.

The Provider shall ensure that, upon discharge of vulnerable/elderly service users, appropriate onward referrals are made to the voluntary sector, eg, Age UK, etc.

GP Notification

Upon completion of treatment, the Provider shall communicate, by way of written letter, the outcome of the treatment to the service user's GP and referrer. This communication constitutes a Clinic Letter and shall be issued by the Provider within two operational days following the service user's discharge. The Provider shall issue letters via first class mail or a secure internet-based solution, eg, NHS Net Mail. The Clinic Letter shall contain:-

- A diagnosis or working diagnosis,
- A Care Plan, including all information that may be required by the referrer and GP to provide ongoing care to service users,
- The correct service user and GP details including what further action the service user's GP is being requested to undertake and the underpinning rationale, in particular, where this relates to the initiation or continuation of medication prescribing,
- All changes in medication, including a letter to the service user explaining that the onus is on them to request the medication (medication being restricted to those items in the joint formulary),

Recommendations regarding the future management of a service user, if appropriate.

3.3 Population covered

The Provider shall provide services to all service users registered with a General Practitioner in Cannock Chase CCG, Stafford & Surrounds CCG and Seisdon Peninsula area for whom the Commissioner is responsible for funding healthcare services.

3.4 Any acceptance and exclusion criteria and thresholds

The Service shall accept referrals as follows:-

- Self/carer referral – if known to the service,
- Ambulance service/NHS 111,
- General Practitioners, Primary Care Teams
- Secondary care services
- Out of Hours service
- Community services

- Intermediate Care Teams/Reablement
- Mental Health
- Learning Disabilities (linking with the Learning Disabilities Clinical Nurse Specialists)
- Social Services
- Therapists
- Hospices

Referrals shall be accepted, via a Single Point of Access, using secure e-mail on the appropriate standardised referral form. Inappropriate referrals shall not be refused but re-directed to the most appropriate service.

Adults over 18 years of age who are registered permanently, or temporarily with a GP, within the geographical area of Stafford & Surrounds at the time that care is needed.

Exclusion Criteria

- People 18 years of age and under (care for people between 16 to 21 may be delivered by paediatric nurses),
- Acute injury/trauma that requires an acute hospital environment to deliver care needs
- Mobile patients

Response Times/Prioritisation of Visits

Routine – service users will be contacted by telephone within 24 hours of receipt of referral to establish that the referral is appropriate and to confirm the date and time band of visit for contact/assessment, eg, chronic disease check, continence assessment, planned visit as per consultant/pathway guidance.

Non-Urgent – access within 48 hours, where clinically indicated, for service users in need of curative care, eg, acute and chronic wound management, post-operative service users, medications.

Urgent – immediate access within a maximum of 4 hours using a clinical prioritisation and patient comfort and safety judgment; for patients in pain, acutely unwell or in crisis, terminally ill patients who want to be cared for at home; visits that can prevent a hospital admission or a visit to an A&E department with reference to clinical tasks listed within 3.2.7.

Prioritisation of service users shall be re-assessed at each visit and the care plan modified, as required, based on their needs. The service user shall be advised of how to access the service including out of hours provision

The Provider shall adopt a consistent approach to measuring workload using a caseload classification system. A systematic approach to data collection shall be adopted, supported by an electronic management information system.

The Provider shall proactively measure demand on the service and capacity available using a tool such as the Warrington Workload Tool. The selected tool shall be consistently applied across the neighbourhood teams. When daily demand exceeds the capacity available, prioritisation of workload will take place using a Red-Amber-Green (RAG) rating to ensure that service users are treated in order of clinical urgency, with input from the referrer.

3.5 Interdependencies

The Provider shall develop strong working relationships with GPs and community based professionals. The Provider shall engage with referrers providing feedback when referrals are rejected together with clear management plans for service users when they are discharged back to the care of the GP.

The Provider shall work in partnership with the following providers to optimise service user care:-

- Community Intervention Service
- Specialist Nursing Team
- Continence Specialists
- Adult Protection
- Therapists
- Social Workers/Assessors
- General Practitioners (GPs)
- Practice Nurses
- Local acute trusts, including specialist centres
- Local NHS community service providers, eg, mental health providers
- Residential Care Homes
- Pharmacists
- Local Authority Departments, including Housing
- Community Equipment This list is not exhaustive.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Provider shall adhere to appropriate national standards, eg, NICE Guidance, NICE Quality Standards, Royal College Guidelines.

The Provider shall be obligated to review the evidence base on a continual basis to ensure compliance with good clinical practice

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Not Used

Service Specification No.	CS_17
Service	District Nursing Service (SES Locality)
Commissioner Lead	Emily Davies
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.1 National Context and Evidence Base

- 1.1.1 High quality care delivered in local communities including people's homes is embedded within national health policy. The importance of improving and extending services to meet the health and care needs of an ageing population and increasing number of service users with long term and multiple conditions is required to meet the growth in need. District nurses, as key professionals, are in a prime position to help plan, co-ordinate and provide this care.
- 1.1.2 A new vision and model for district nursing (2013, Department of Health (DoH)) to meet future health needs sets out a national strategy set within a framework of 'Compassion in Practice'. It places the values or '6Cs' of care, compassion, competence, communication, courage and commitment at the heart of district nursing service delivery. It requires new types of care which will:-
- Focus on enabling the shift in care from acute to community settings,
 - Enhance the partnership between district nursing, health, social care, voluntary sector and service users to support care in people's homes (including residential care homes) and in other community settings,
 - Promote and support self-care and the role of the district nurse as an enabler,
 - Tackle social isolation and mental, as well as physical, health needs, especially for those that are frail and elderly,
 - Promote the district nurse as a leader and case manager for complex care when it is needed and provide skilled care in acute episodes, long term conditions and at end of life.
- 1.1.3 The current evidence base for delivering nursing care is detailed below, this list, however, is not exhaustive:-
- Care In Local Communities: A new vision and model for district nursing (2013) DoH NHS Commissioning Board
 - District Nursing – Harnessing the Potential (2013) Royal College of Nursing
 - Delivering Care Closer To Home: Meeting the Challenge (2008) DoH

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

- Ensure that clinical interventions support earliest return to independent living
- Support those with long term conditions to remain at home as independently as possible

- Enable patient choice of place to die at end of life; at present for South East Staffordshire & Seisdon CCG 39.7% of individuals die at home (46% in hospital) and an increase of at least 5% is required. The national average is 38.1%.
- Reduce % of patients re-admitted to acute hospital within 30 days of discharge
- Increase service user satisfaction with the quality of nursing care and communication with the service
- Delivery of patient centred care through integrated working with health and social care providers, including attendance at MDT meetings in primary care settings for patients on their caseload with complex care needs
- Increased awareness on the part of patients and their carers of health improvement opportunities including prevention and self-care

3. Scope

3.1 Aims and Objectives

- 3.1.1 The Provider shall deliver a Community Nursing Service to housebound patients in their own home, with the exception of ambulatory individuals requiring complex wound care.

The definition of a housebound individual is:-

'Patients who have proven morbidity and who are genuinely unable to leave their home, either on a short term or long term basis and where there is a nursing need.' – District Nursing Referral Guidelines 2013

The definition of an ambulatory individual is:-

'Patients who are physically able (with or without assistance) to access clinic, minor injury unit or GP Practice / Walk In Centre.' – District Nursing Referral Guidelines 2013

- To deliver seamless nursing care which is proactive, integrated, innovative, well-managed and co-ordinated to support adults with a health related need through a period of transition, acute care, long-term care and palliative care.
- To improve health and wellbeing outcomes by delivering appropriate treatment whilst supporting and facilitating self-care.
- To provide generalist palliative care for service users who are suffering a life-threatening illness, cancer or non-cancer and who wish to die in their home environment.
- To provide a co-ordinated approach to discharge that facilitates a seamless transition from acute care and leads to better health outcomes.
- To promote health and wellbeing and reduce health inequalities by offering advice and information in the most appropriate way to the service user.
- To provide innovative care and services that will actively manage an anticipated year on year increase in demand.

- 3.1.2 The Service objectives are to contribute to the delivery of the vision for South East Staffordshire & Seisdon Clinical Commissioning Group (CCG); high quality healthcare services to ensure people live healthier, longer lives:-

- To provide holistic care for all adults referred to the service, ensuring shared decision making to meet individual health needs.
- To provide high quality, culturally sensitive nursing care for people in their own homes or community setting to enable service users to continue to live independently in their own home.
- To avoid unnecessary hospital admissions and facilitate early discharge from acute and short-term residential care.
- To support service user choice at end of life by fulfilling their goal of dying in their preferred place of death.
- To collect service user outcome data including Quality of Life.
- To comply with national waiting targets and other key national and local quality and performance targets.

- 3.1.3 South East Staffordshire & Seisdon CCG has agreed the following principles for compliance to transform District Nursing service delivery:-

- Integrated health and social care teams.
- A proactive approach that is responsive and innovative, providing advice on assistive technologies such as telehealth and telecare.
- Application of lean philosophy to deliver productivity gains underpinned by efficiency and effectiveness in operational management, enabled through remote working and technology.
- Escalation and de-escalation of service users, within the model of care, to provide the right care, by the right health professional, at the right time.
- Fostering a culture of continuous service improvement.

3.2 Service Description/Care Pathway

- 3.2.1. The Provider shall provide nursing care, through identified packages of nursing care, for housebound adults who have short term needs, long term conditions, complex needs from multiple conditions, or require palliative care and end of life care. Where a patient becomes ambulant during the course of their nursing care, the service shall continue to deliver care in accordance with an agreed Estimated Discharge Date with the District Nursing service to another provider, if required.
- 3.2.2. The Provider shall work in partnership with individuals, families, carers, primary care teams, acute and social care, mental health teams and specialist nurses, independent and voluntary sectors, providing a range of interventions and services to assist service users to maximise their quality of life, promote independence and improve their health.
- 3.2.3. The Provider shall comply with the new model of 'Care in local communities, *A new vision and model for district nursing* (DH, 2013) to meet the health needs of the population. This shall be achieved through the District Nursing Service providing care and support in the community, including peoples' homes, that encompasses three core elements of population and caseload management, support and care for service users who are unwell, recovering at home and at end of life and support and care for independence.

Core Elements

- 3.2.4. **A comprehensive initial assessment*** of service users accepted by the service, including:-
- The agreement of personal goals/outcomes,
 - The creation of an individual care plan which determines the best environment for the delivery of the nursing care package; the service user's home (temporarily or permanently housebound), or in a community setting (eg, wherein the service user becomes ambulant during the delivery of a package of nursing care, or in cases where the practitioner has determined that the service user is fit to attend a community clinic setting for services such as wound care),
 - Appropriate onward referral to specialist services following assessment, where appropriate, eg, the Multi-Factorial Risk Assessment (FRAT) to the Falls Prevention Team, the Malnutrition Universal Screening Tool (MUST) to community dieticians, pain tool to the chronic pain team.

* It is recognised that a comprehensive assessment may not be needed for all service users dependent upon the nursing task to be delivered.

- 3.2.5. **Ongoing assessments** shall include daily monitoring and treatment based on the professional's clinical judgment for:-
- Continence to include residential home patients
 - Falls – Level 1 falls assessment to support the delivery of the local Falls strategy,
 - Long term conditions as required as part of the service user's ongoing package of care for individuals that are housebound, or find it difficult to access regular healthcare
 - Palliative care and end of life service users.
- 3.2.6. **Identification and acknowledgement of carer needs** using assessment tools which form part of the care management process, where appropriate, signposting carers to suitable alternative support services, including social care and third sector services.
- 3.2.7. **Clinical Tasks**
- Public health services, including participation in immunisation programmes for older people, eg, influenza and those with long term conditions on the nursing caseload,
 - Advice / guidance for individuals and families during treatments and life changing events, eg, amputation, mastectomy as part of immediate post-surgery care, bereavement,
 - Provision of pain management and symptom control for terminally ill service users, delivery of End of Life care which supports and ensures the use of End of Life tools including advanced care plans and, where appropriate, ensuring referral and access to Specialist Palliative Care (SPC) services, third sector and other relevant community based services for service users/carers at End of Life,
 - Care and management of tracheotomies – short term intervention to support patients, families and carers with self-management and wound care
 - Verification of death (out of hours for nursing caseload),
 - Phlebotomy – venepuncture for service users at home and in residential settings where there is regular and ongoing District Nurse intervention that requires phlebotomy as part of a service user's package of nursing care,
 - Simple and complex wound care,
 - Pressure ulcer prevention and management for patients,

- Ear syringing,
- Performing catheterisation,
- Trial without catheter (TWOC)
- Continence – assessment for provision of continence supplies and referral to specialist continence services, support for those with dwelling catheters and catheter care (care of urethral/supra-pubic catheters),
- Supporting bowel management pathways,
- Management of PleurX chest and breast drains,
- Management of diabetes,
- Doppler assessments (see attached criteria),,
- Medication management including the administration of medication,
- Nurse formulary and non-medical prescribing against a clearly defined formulary,
- Continuing Health Care – brokering packages of care for service users at the end of their life.

To maintain wellness and support health improvement to the best possible level, to ensure that service users and their carers are appropriately informed, involved and supported to promote their role in the safe delivery of their care, including self-care.

3.2.8 **Long Term Conditions Multi-Disciplinary Team Meetings** – an appropriate member of the nursing team may be required to attend a Multi-Disciplinary Team for service users that are part of the active caseload.

3.2.9 **Rehabilitation/Reablement** – the Service shall link with other providers to support efficient and seamless service user journeys.

3.2.10 **Access to intermediate care beds** – where appropriate, South East Staffordshire service users shall be referred to Intermediate Care beds within the wider health locality, when referred via the Single Point of Access.

3.2.11 **Advance Care Plan** – the teams will take an active role in advance care planning for palliative and end of life patients, this will support patient choice around preferred place of care.

3.2.12 **Neighbourhood Model** – teams shall be aligned to geographical areas in Neighbourhoods: Tamworth consisting of East, West A and West B and Lichfield 1 and Lichfield 2 (Burntwood) with each GP practice being kept advised of which District Nurse is the allocated key worker for each patient together with a suitable alternative contact in the key worker's absence.

3.2.13 **Hours of Operation** – provision to be 0830 to 1715 hours with Out of Hours District Nursing 1715 to 2215 hours, 7 days per week, 365 days per year, via a Single Point of Access to each team and interface with the Intermediate Care Team for seamless service transition for service users and cover after 2215hours until 0830hours. Service provision must be planned around patient need and demand.

3.3 Population covered, acceptance, exclusion criteria and referral source

3.3.1 Population Covered

The Provider shall provide services to all service users registered with a General Practitioner in **South East Staffordshire CCG** area (not Seisdon CCG area) for whom the Commissioner is responsible for funding healthcare services.

3.3.2 Acceptance Criteria

The Service shall accept referrals as follows:-

- Self/carer referral – if known to the service,
- Ambulance service/NHS 111,
- General Practitioners, Primary Care Teams
- Secondary care services
- Out of Hours service
- Community services
- Intermediate Care Teams/Reablement
- Mental Health
- Learning Disabilities (linking with the Learning Disabilities Clinical Nurse Specialists)
- Social Services
- Therapists
- Hospices

Referrals shall be accepted, via a Single Point of Access, using secure e-mail on the appropriate standardised referral form. Inappropriate referrals shall not be refused but re-directed to the most appropriate service.

Adults over 18 years of age who are registered permanently, or temporarily with a GP, within the geographical area of South East Staffordshire at the time that care is needed.

3.3.3 Exclusion Criteria

- Patients in Seisdon CCG area

- People 18 years of age and under (care for people between 16 to 21 may be delivered by paediatric nurses),
- Acute injury/trauma that requires an acute hospital environment to deliver care needs
- Mobile patients

3.4 Response Times/Prioritisation of Visits

Routine – service users will be contacted by telephone within 24 hours of receipt of referral to establish that the referral is appropriate and to confirm the date and time band of visit for contact/assessment, eg, chronic disease check, continence assessment, planned visit as per consultant/pathway guidance.

Non-Urgent – access within 48 hours, where clinically indicated, for service users in need of curative care, eg, acute and chronic wound management, post-operative service users, medications.

Urgent – immediate access within a maximum of 4 hours using a clinical prioritisation and patient comfort and safety judgment; for patients in pain, acutely unwell or in crisis, terminally ill patients who want to be cared for at home; visits that can prevent a hospital admission or a visit to an A&E department with reference to clinical tasks listed within 3.2.7.

Prioritisation of service users shall be re-assessed at each visit and the care plan modified, as required, based on their needs.

The service user shall be advised of how to access the service including out of hours provision.

The Provider shall adopt a consistent approach to measuring workload using a caseload classification system. A systematic approach to data collection shall be adopted, supported by an electronic management information system. The Provider shall proactively measure demand on the service and capacity available using a tool such as the Warrington Workload Tool. The selected tool shall be consistently applied across the neighbourhood teams. When daily demand exceeds the capacity available, prioritisation of workload will take place using a Red-Amber-Green (RAG) rating to ensure that service users are treated in order of clinical urgency, with input from the referrer.

3.5 Interdependence with other services/providers

3.5.1 The Provider shall develop strong working relationships with GPs and community based professionals. The Provider shall engage with referrers providing feedback when referrals are rejected together with clear management plans for service users when they are discharged back to the care of the GP.

3.5.2 The Provider shall work in partnership with the following providers to optimise service user care:-

- Community Intervention Service
- Specialist Nursing Team
- Continence Specialists
- Adult Protection
- Therapists
- Social Workers/Assessors
- General Practitioners (GPs)
- Practice Nurses
- Local acute trusts, including specialist centres
- Local NHS community service providers, eg, mental health providers
- Residential Care Homes
- Pharmacists
- Local Authority Departments, including Housing
- Community Equipment

This list is not exhaustive.

3.6 Discharge Arrangements

3.6.1 Upon completion of the package of care, or where regular review is not required, usually due to the achievement of medical stability, the service user shall be discharged from the caseload to self-care or normal management plan.

3.6.2 Service users that move out of the area shall be transferred to their subsequent health provider by the Provider.

3.6.3 Where appropriate, discharge planning shall be discussed from the day of admission to the nursing caseload. The service user shall have a clear plan and expected outcomes with predicted timeframes, if possible, and review date(s).

3.6.4 When a service user is transferred to another provider service a summary of the assessment and care given shall accompany the service user and the service user's General Practitioner shall be advised by the key worker/service.

3.6.5 The Provider shall ensure that, upon discharge of vulnerable/elderly service users, appropriate onward referrals are made to the voluntary sector, eg, Age UK, etc.

3.7 GP Notification

3.7.1 Upon completion of treatment, the Provider shall communicate, by way of written letter, the outcome of the treatment to the service user's GP and referrer. This communication constitutes a Clinic Letter and shall be issued by the Provider within two operational days following the service user's discharge. The Provider shall issue letters via first class mail or a secure internet-based solution, eg, NHS Net Mail. The Clinic Letter shall contain:-

- A diagnosis or working diagnosis,
- A Care Plan, including all information that may be required by the referrer and GP to provide ongoing care to service users,
- The correct service user and GP details including what further action the service user's GP is being requested to undertake and the underpinning rationale, in particular, where this relates to the initiation or continuation of medication prescribing,
- All changes in medication, including a letter to the service user explaining that the onus is on them to request the medication (medication being restricted to those items in the joint formulary),
- Recommendations regarding the future management of a service user, if appropriate.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- 4.1.1 The Provider shall adhere to appropriate national standards, eg, NICE Guidance, NICE Quality Standards, Royal College Guidelines.
- 4.1.2 The Provider shall be obligated to review the evidence base on a continual basis to ensure compliance with good clinical practice.

5. Applicable quality requirements and CQUIN goals

- 5.1 Applicable quality requirements (See Schedule 4 Parts A-D).** Reporting of the following Local Quality Requirements and Reporting Requirements will begin in January 2017 when the December 2016's data will be issued to commissioners by the 15th operational day.

Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
All referrals will be acknowledged and contacted by telephone within one working day of receipt to establish that the referral is appropriate and to confirm date and time band of visit	95%	Lorenzo	GC9 Contract Management
Non-urgent referrals will receive access to the service with 48 hours of referral, where clinically appropriate	95%	Lorenzo	GC9 Contract Management
Urgent referrals to be offered access to the service within a maximum of 4 hours, where clinically appropriate	95%	Lorenzo	GC9 Contract Management
Service users to have a care plan which includes expected outcomes with predicted timeframes and is re-assessed at each visit	95%	Lorenzo	GC9 Contract Management
Clinic letter to be sent to the patient's GP and referrer within two operational days following discharge of the service user	95%	Lorenzo	GC9 Contract Management
Service users at end of life are accepted into the service when referred and support	100%	Annual audit of 20 patients	GC9 Contract Management
Venous leg ulcers should heal within 24 weeks of diagnosis	90%	Lorenzo	GC9 Contract Management
Improvement in patient and carer experience	95% of service users receiving care report a good experience	User and Carer Patient Experience Survey - 20 patients per month	GC9 Contract Management
Increased clinical contact time (face to face) with the service user increasing quarterly	Baseline of 40% with 1% improvement per quarter (to be reviewed end of 2016/17)	Lorenzo	GC9 Contract Management
Service users on the district nursing caseload to be offered a pneumococcal and/or flu vaccination if appropriate by the end of January each year	100%	Spreadsheet	GC9 Contract Management

Pneumococcal and/or Flu vaccination to be administered to all eligible service users who accept the offer and GP practice notified within two working days of vaccination	100%	Spreadsheet	GC9 Contract Management

Reporting Requirements

Title	Reporting period	Format of Report	Timing and Method for delivery of report	Application
Number of referrals received by District Nursing split by a) source b) primary diagnosis c) day d) time of day	Monthly		Lorenzo	
Number of inappropriate referrals received (by referrer) and reasons why	Monthly		Lorenzo	
Number of referrals not responded to within the specified time and reasons why	Monthly		Lorenzo	
Number of patients on caseload at month end split by type	Monthly		Lorenzo	
Number of patients on caseload at month end split by RAG rating	Monthly		Lorenzo	
Number of service users with a care plan	Monthly		Lorenzo	
Number of discharged patients together with LoS and number of interventions	Monthly		Lorenzo	
Number of clinic letters sent to GPs of discharged patients	Monthly		Lorenzo	
Amount of face to face time spent with each patient	Monthly		Lorenzo	
Number of patients offered a pneumococcal and/or flu vaccination	Annually by end of February		Spreadsheet	
Number of patients who received a pneumococcal and/or flu vaccination	Annually by end of February		Spreadsheet	
Number of patients requiring a TWOC	Monthly		Lorenzo	
Number of patients requiring care and management of a drain following breast surgery	Monthly		Lorenzo	
Number of patients requiring tracheostomy care	Monthly		Lorenzo	

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

Service Specification No.	CS_18
Service	Community Nursing Service (North Staffs and Stoke)
Commissioner Lead	Sharon Cooper
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.2 National/local context

Primary care is undergoing a period of transition with a move away from isolated teams and providers of care to a new model of closer collaboration and shared responsibilities between health and social care domains with the creation of Multi-specialty Community Provider (MCP) teams. Ultimately MCP's will have the responsibility to meet the care needs for defined local population hubs, community nursing services are an essential element to meet this vision. Previously community nursing teams have been commissioned separately leading to a number of stand-alone teams working to individual specifications.

It is evident that improved integration of community nursing teams with each other as well as wider primary care services will facilitate implementation of the emerging MCP model to the benefit of the population of Northern Staffordshire. In future community nurses will form multi-professional teams joining up all elements as part of a single co located unit.

It is also the case that community nurses are managing an increasingly complex case load with rising demand due to demographic changes with a growing emphasis on the provision of treatments and interventions within the community setting wherever possible. Therefore closer alignment and integration of community nursing elements with each other and wider primary care teams will provide an improved infrastructure to meet this aim.

Community nursing therefore needs to realign to meet these current and future challenges and deliver the following priorities:

- Enable the on-going shift in care from acute to community settings
- Enhanced partnership between community nursing teams, health based primary care teams, social care, voluntary sector partners and patients and their families/carers to support care in people's homes including provision from Community Care Hubs , residential care homes and in other community settings
- Promote and support self-care and the role of the community nurse as an enabler
- Ensure that mental as well as physical health needs are considered and referred to appropriate specialist services as required
- Community nurses are co-located and to work collaboratively to support the wider primary care team to prevent unnecessary hospital admission through proactive management of individuals with complex care needs including acute exacerbations
- Work collaboratively with the wider primary care team including palliative care services to provide Palliative and End of Life care within the community setting

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

- Increased proportion of individuals with a palliative diagnosis dying within the community setting
- All individuals with a palliative diagnosis will have a clearly written management plan related to escalation and ceilings of care
- Support reduction in the number of Non Elective (NEL) for defined population catchment areas¹
- Increased clinic capacity available 7 days per week with a reduction in home visits for those that would be suitable for ambulatory care. Where clinically appropriate house visits will continue for those patients assessed as housebound
- Closer alignment of community nursing teams to GP practices
- Improved patient satisfaction with service
- Through outreach support the reduction of DNAs to traditional clinic venues, maximise service efficiency and improve clinical outcomes for the difficult to reach patients

3. Scope

3.1 Teams Included within this specification

This spec will include the teams previously identified as District Nursing; Out of Hours Nursing and Community Matrons who will form the new Community Nursing Service.

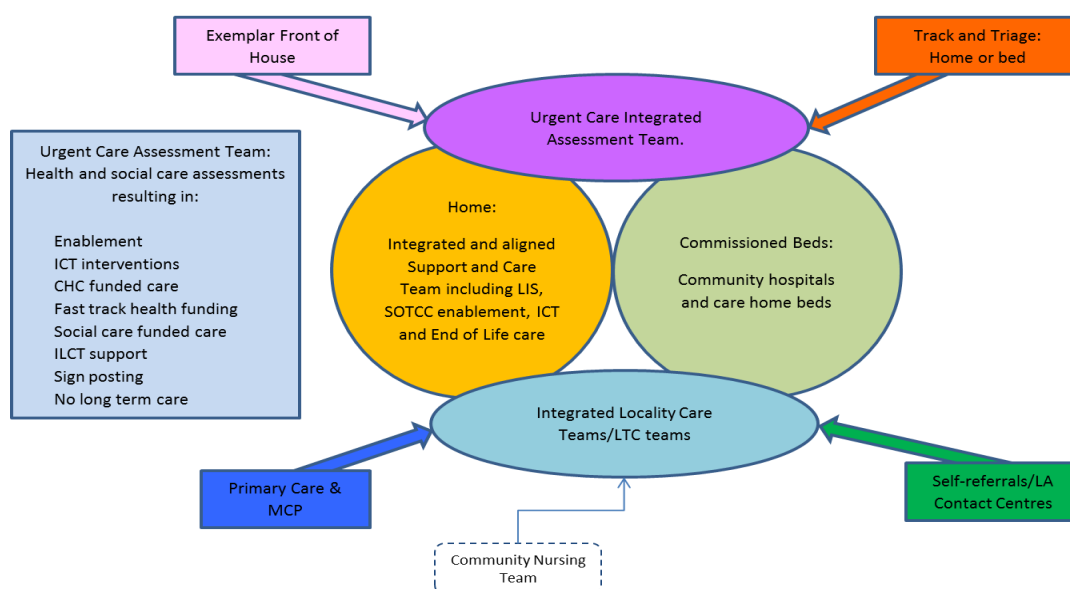
Aims and objectives of service

The aim of community nursing is to work collaboratively in providing safe and effective holistic nursing care to people in or within a community location, enabling people to make choices, self-manage and maintain control over their quality of life.

The Community Nursing team will provide nursing services utilising a holistic model of care for housebound adults. The Community Nursing team shall provide the service for ambulatory adults for specific conditions, for example complex wound care.

The Community Nursing team will promote healthier lifestyles, physical, social and psychological wellbeing and support. The service will provide a service to people with a range of health conditions to live independent lives with a focus on avoiding hospitalisation. The nursing service will provide advice, support, and a comprehensive range of treatments that enable individuals to remain at home (or usual place of residence including care homes) avoiding unnecessary hospital admission. It is intended that the Community Nursing Service will form part of the Discharge to Assess pathway through the Integrated Locality Care Teams/LTC teams.

Home First - Discharge to Assess and Prevention of Admission Model



¹ A non-elective admission is one that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from another hospital bed from another care provider.

The community nursing service will offer a range of care from simple treatments, to assessment and management of deterioration of health within the community setting in a proactive manner, including management of individuals with palliative/end of life needs as part of the wider primary care infrastructure.

The Community Nursing Team will: -

- Contribute and provide patient centred care that is co-ordinated through integrated working with health and social care
- As part of the Discharge to Assess pathway through the Integrated Locality Care Teams/LTC teams , provide home based nursing care that enables individuals to remain within the community setting avoiding unnecessary hospital admissions
- As part of the Discharge to Assess pathway through the Integrated Locality Care Teams/LTC teams, facilitate timely discharge from hospital and appropriate community follow on care to prevent hospital readmission working with the emerging discharge to assess model
- Offer a responsive service to individuals with a range of health conditions who are at risk of hospitalisation including physical health assessment and prescribing where necessary
- Contribute to the reduction health inequalities for the most vulnerable population, i.e. housebound, homeless, patients with multiple long term conditions through innovative working
- 'Contribute to the reduction and risk of avoidable pressure ulcers referring to appropriate services as required
- Contribute to the reduction and risk of avoidable falls referring to appropriate services as required
- Ensure that patients are discharged from the service in line with their Expected Date of Review and Expected Date of Discharge (EDD) where appropriate
- Work in partnership to support patients in Advanced Care Planning (ACP) participating in conversations as early as possible with patients and carers
- Ensure that individuals are supported to die in their place of choice where possible
- Develop, and maintain successful collaborative working practices across Community, Primary Care, Secondary Care, Voluntary and Independent sector organisations and social service as active members of the Multi-Disciplinary Providers (MCP) hub
- Adhere to the principles and requirements of legislation surrounding the process of safeguarding (adults and children)
- Undertake risk assessments and risk mitigation to ensure interventions can be delivered safely in people's homes for individuals who cannot attend a community nursing clinic
- For patients on the caseload, deliver proactive and anticipatory care, working with individuals and carer's to enable them to recognise acute or chronic changes in their condition or wellbeing, using advanced practice skills for assessment, diagnosis and prescribing – Prescriptions should be generated by the Community Nursing team within their competence; with the escalation point for Community Nursing Staff being the Senior Community Nurse on rota band 6 or above
- Will have a designated independent prescriber available Monday-Friday with cover provided on an on-call basis utilising cross cover from individual teams – with a commitment to delivering 7 day working
- Support patients to be empowered and confident in managing their conditions, wellbeing and own health needs, and to take responsibility for their self-care through behavioural change or coaching strategies
- Escalate and de-escalate patients, within the model of care, to provide the right care, by the right health professional, at the right time
- Demonstrate effective use of technology, promoting its use with people in their care
- Demonstrate effective management of caseloads, workloads and resource utilisation
- Work within the principles of D2A supporting the ethos of the home first approach

3.2 Service description/care pathway

The Community Nursing team consists of a range of nurses and support workers with the appropriate skill mix to proactively manage the caseload to support effective caseload and workload management for example:

- Senior Community Nursing Leadership – Band 6 or above
- District Nurses
- Community Staff Nurses
- Health Care Support Workers
- Assistant practitioners
- Phlebotomists

It is envisaged that the community team will have senior clinical leadership by assigned community matrons who will support and oversee the coordination of care to the wider community as part of the Community Care Hubs and emerging MCP model. Community matrons will also be expected to deliver direct care to individual patients who are deteriorating within the community setting to include health assessment and prescribing where necessary as part of the role of collaborative working with the wider community nursing team.

Each community team will have dedicated clinical leadership at an appropriate level.

The Community Nursing service for each locality hub will have a single referral point for triage and initial assessment to enhance care coordination ensuring support from the most appropriate healthcare professional based on the needs of the patient.

The service will work in collaboration with GP practices to support risk stratification for case finding, to identify members of their population that may benefit from additional clinical intervention, as directed by a lead clinician such as the patient's GP.

The service shall work as part of an integrated team (this may be a virtual team) which includes GP Practice teams, Specialist Nurses, Secondary Care, Therapists, Social Care and the Voluntary Sector to provide a holistic model of care. To achieve this, the Community Nursing team will be an integral part to the emerging MCP model.

The team shall provide care to

- housebound patients in their own home,
- ambulatory individuals requiring complex wound care.

Housebound

The definition of a housebound individual is as prescribed below, and is defined by capability rather than **age or social circumstances**: -

'People who have proven morbidity and who are unable to leave their home, either on a short term or long term basis and where there is a nursing need.'

The patient will be deemed to be housebound when they are unable to leave their home environment through a physical and/or psychological condition. In assessing whether a patient is considered housebound an assessment should be undertaken considering the nature of the treatment / surgery they have received, which may temporarily make them housebound.

Please note that the provision of housebound care also includes patients within nursing homes, see section 3.4 for further clarification.

Ambulatory

'The definition of an ambulatory individual is:

'Patients who are physically able (with or without assistance) to access clinic, minor injury unit or GP Practice/Walk in Centre'.

GP Wound Services – Practice Nurse

For clarification as to the responsibility of the practice nurse work in wound care. they will undertake the care of simple wounds as defined below.

Simple wound care for ambulatory patients undertaken by the Practice Nurse² (Children and Adults) following a minor surgical procedure includes suture/clip removal and application of any associated dressings, application of dressings following a minor surgical procedure.

A Simple wound is defined as - when the wound is superficial that is, involving primary epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures and requires simple one layer bandaging/dressing.

Wounds for ambulatory patients which match the above 'Simple Wound' criteria should be managed by a practice nurse within the individuals GP surgery. Wounds which do not fit within this definition need to be managed by the community nursing team.

Please see appendix one for further definitions and clarification

Innovation in the Management of wound care

² <http://www.practicenurse.co.uk/index.php?p1=a-z&p2=wounds-and-wound-care>
https://rcni.com/sites/rcni_nspace/files/ns.30.27.40.s45.pdf

To support the integration of community and primary care services and national guidance on wound care – this element of the service specification will be reviewed through an integrated Clinical Review Group consisting of Commissioners, Primary and Community Services that will future proof community nursing and primary care services as Staffordshire moves into delivering locality hubs ensuring that there are no gaps in services provided between primary and community services.

Services for **Housebound Patients** by Community Nursing Team

- Simple and complex wound care
- Caring for complex post-operative individuals including wound care management and advice
- Care for individuals with palliative and End of Life care needs, including symptom management, supportive care, enabling of individuals to die in their place of choice – often at home, support to family/carers, continuity of care by a key worker and the GP
- Management of individuals with health conditions who are at high risk of deterioration or crisis, providing proactive care and support and promoting enablement and independence. Management includes health assessment, prescribing of appropriate medications to prevent further deterioration and prevent hospital admission for high risk individuals
- Medication management including the administration of non-oral medication for patients who are unable to self-manage
- Education, support and review of individuals self-administering medication as part of enabling the patient to self-care
- Continence management and advice , including continence assessment and review, catheter care, intermittent catheterisation, urethral, supra pubic, stoma care, for patients possibly in retention and bowel management a referral to the specialist service Community Continence service should be made as appropriate
- Nutritional monitoring and/management where clinically indicated
- Support the delivery of immunisation and vaccination programmes for housebound individuals who are already on the Community Nurses caseload
- Verification of expected death for patients on community nursing caseload
- ABPI (Doppler) measurement for housebound patients for patients with a leg wound (see exclusion criteria)
- Management of individuals with IV/Hickman/PICC Lines and administration of IV Therapy and S/C fluids including PEG medication as per locally agreed protocol
- Advice/guidance and emotional support for individuals and families during treatments and life changing events e.g. amputation, mastectomy as part of immediate post-surgery care and bereavement, with referral to specialist services where appropriate
- Pressure ulcer prevention, management and education for patients including *ankle-brachial pressure index* (ABPI) measurement for housebound patients, and carers on the caseload.
 - *So where pressure care mattress are prescribed, then the expectation is that the patients care plan includes details of stepping down*
- Referral to speciality community teams as appropriate for the individual patient
- Support the management with drainage of long term drains if the individual patient is unable to oversee independently
- Coordination of care between various community health based teams and social care to ensure seamless transition and avoid duplication
- Taking blood samples for housebound patients
- Clinical interventions that can be safely delivered /managed in the community and in the patient's home for example (but not limited to); IV antibiotics; subcutaneous fluids in line with and support of the Discharge to Assess Pathway. Nurses must check they have all the documentation and medication needed to start treatment. Unless otherwise instructed, administration will be in accordance with NMC guidelines, manufacturer's guidance and local protocols and guidelines
- Ear irrigation for housebound patients

Clinic based services

The service will provide clinic based facilities for the treatment of : -

- Complex wounds (complex wounds are fungating lesions, leg and diabetic ulcers, wounds that require packing, removal of post-surgery wound staples and non-healing wounds, in line with agreed national and professional guidelines
- Simple wounds that have been referred from the GP in line with agreed national and professional guidelines
- Urinary catheter replacement and Trial without catheter
- Administration of low molecular weight heparin for ambulant patients who are unable to self-inject and provision of training to encourage self-injection including carers if necessary
- Provision of Outreach facilities to provide complex wound care within service locations that provide support and care to vulnerable patients such as those classified under the PSED as other disadvantaged groups and protected groups

Referrals to Community Nursing Team

Referrals to the service will be received from a variety of sources It is expected that some of these (but not exclusively) will be : -

Using the appropriate documentation through the local access points and triaged appropriately.

The referral will contain relevant details to ensure information is available prior to the first visit and to enable appropriate triage.

- GP/Primary Care and Out of Hours Doctors
- Consultants/Secondary Care
- Community Intervention Service
- Outreach services – e.g. Homeless
- Social Care
- Residential Home
- Occupational Therapy
- Physiotherapy
- Podiatry
- Hospice at Home/Douglas Macmillan Hospice
- Tissue Viability
- Community Hospitals/carers
- Ambulance service

In the event of a referral being made through the local access point which does not meet the criteria for the Community Nursing Service, will discuss the issue with the referrer to agree a way forward. However, to avoid any delay in patient care the patient should be seen or referred to the relevant team as appropriate.

Clinical Data Management

- The service shall maintain a single record of clinical interventions which will be accessible at the point of treatment and available to patients on request for the duration of the time that the patient is on the caseload. To ensure that this remains a single record the service will ensure that any IT solutions will be interoperable. Working with the GP practices it supports, where the practice allows it, the service shall have an open dialog with practices about access and input into GP clinical system data where clinically indicated and in support of patient care
-
- The Provider will work with the local health economy to work towards the development of an integrated Care Record

Prescribing

- The Community Nurse Service will be responsible for appropriate prescribing requests related to nursing care managed within service
- Community nurse prescribing should be in line with the North Staffordshire & Stoke-on-Trent Joint Formulary and staff competence in line with NMC guidance and policy as a minimum requirement
- Community nurses will also be required to comply with other formulary requirements which have been endorsed by the Area Prescribing Committee e.g. Dressings Formulary

Principles of Service Operation

- Community nursing teams shall be aligned to one or more locality care hubs as agreed with commissioners and will be sufficiently resourced to meet the demand of the areas. Local flexibility will be given on order to ensure a safe service
- Adequate number of clinics to alongside appropriate home visits
- Provision of both 'step up' and 'step down' care as appropriate
- Each team will be located in premises as agreed locally or as close to the locality hubs it services. This will be reviewed annually with Primary Care and the Provider
- Day-to-day contact/communication between members of the Nursing Service and GP practices must occur as required and determined by patient and caseload need
- The Community Nursing team will also be represented at GP practice meetings. Where it is applicable to attend, for example: discussion of complex patients
- A system for sharing caseload information must be in place to support coordination of care, avoid duplication of care and ensuring the most appropriate health care professional is involved based on the current needs of the patient
- The team will have the appropriate skill mix for the population it serves; senior clinical leadership (24 hour cover) will be provided by at least senior nurse grade 6 or above
- If care is required in the out of hour's period, the Community Nurse will hand over the care to the most appropriate out of hour's service, i.e. the Community Nurse out of hour's service or the GP out of hour's service. The service will ensure that there is an overlap period between in and out of hour's Nursing Services ensuring that there are no gaps in provision and that agreed protocols and handover arrangements are in place to support this
- Discharge planning from the caseload shall begin at the time of admission to the Community Nursing Service with an Expected Date of Review or/and Expected Discharge Date (EDD) clearly stipulated as appropriate

- All prescribing relating to the Community Nursing Service are required to be managed within the service. The Community Nursing Services will be expected to ensure that there are an adequate number of Community Nurses trained to V100 prescribing qualification standard or equivalent to ensure that there is 7 day coverage as applicable.

Days/Hours of Operation

The Community Nursing Service is delivered (365 days a year) 24 hours per day. Staffing should be managed to ensure the provision of a full 7 days service including weekends.

Processes to ensure the safe and clinically effectiveness of hand over's between days, evening and night teams must be in place to ensure the continuum and or completion of the care plan intervention.

Continuity of Service

The Community Nursing Service will proactively manage anticipated changes in demand and continuity planning. Through flexibility and responsiveness to changing demands and pressures.

The Community Nursing service will ensure that where there are vacancies or staff absences that have an impact on the continuity of service provision that these are adequately covered to ensure that patients receive appropriate and continued care. Where there is an impact on continuity the Community Nursing Service will undertake appropriate risk assessment on the patients involved to ensure that their immediate needs are assessed and met and that their long term needs are understood and managed on an ongoing basis.

Prioritisation of visits

There are no waiting list, but visits to patients will be prioritised as following:

Urgent

- Immediate access within a maximum of 4 hours using a clinical prioritisation and patient comfort and safety judgment: for patients in pain, acutely unwell or in crisis, terminally ill patients who want to be cared for at home; visits that can prevent a hospital admission or a visit to an A & E Department, e.g. blocked catheters, patients in need of intensive nursing care e.g. diabetes, cancer, chronic diseases etc.

Semi-urgent

- Acknowledged within 4 hours and seen within 24 hours dependent upon requirement e.g. acute and chronic wound management, post-operative patients, bereavement and medications.

Planned

- Visited at a defined or negotiated time directed by care need and agreed with referrer and individual - patient contacted by telephone call to confirm date and time band of visit (e.g. catheter change, immunisations, planned following surgery).
- All referrals will be acknowledged and contacted by telephone within one working day of receipt where applicable to establish that the referral is appropriate and to confirm date and time band of visit.

SSOTP will work towards managing the above through a central triage centre that will introduce standard processes and pathways to provide continuous triage, review and prioritising of all referrals and requests for visits in order to best utilise resources across the Community Nursing Service.

Discharge Criteria/Planning from the Community Nursing Service:

- Patients shall be discharged from the Community Nursing Service once the nursing needs are met and treatment completed ensuring that the patient can self-care or/and have appropriate step down care is sourced, i.e. social care, voluntary sector following assessment. This includes referral to social care colleagues who are part of the same integrated team.
- Discharge planning shall be discussed with the patient, carer and representative (with patient permission) from the day of admission to the Community Nurse caseload. This relates to all patients with the exception of those requiring "end of life" care and management. The patient shall have a clear plan and expected outcomes with predicted timeframes in line with expected date of discharge as appropriate which will include the return of loaned equipment as appropriate.
- Individual care plans shall be fed back to the GP practice, for example, in the form of a discharge summary as agreed locally to ensure clinical records are kept up to date on completion of the episode of care. Information regarding patients receiving on-going care to an agreed data set shall be fed back on as agreed with the practice, at a minimum of every 6 months unless the complexity of the patient requires more frequent updates.

DNA (Access Policy)

- A patient DNAs when they do not attend a planned appointment, (face to face or telephone call) and provide no advanced warning, or arrive late to an appointment and are not able to be seen
- Unable to Attend Appointment (UTA) where a patient provides prior notice that they are unable to attend an appointment, they are recorded as being 'Unable to Attend'. This is also known as a cancellation
- The provider shall use a risk and needs based approach in its response to DNA's which includes assessment in line with Adult Safeguarding Policies
- Where a patient has failed to attend an appointment they will be offered one further opportunity to attend before the provider returns the referral back to the referring GP
- In regard to DNA - Discharging the patient must not be contrary to the patient's best clinical interests (or there is no prior knowledge of the patient having a lack of capacity to refuse or decline treatment)

3.3 Population covered

Patients 18 years or over, registered with a North Staffordshire or Stoke-on-Trent GP.

In addition, service users between the age of 16 and 18 who choose and where it is clinically appropriate to access adult services. There will be open dialogue with the service user and between the Community Children's Nursing Service and the Community Nursing Service to determine the most appropriate nursing service to meet their nursing need.

Timely proactive engagement should take place between the Children's Community Nursing Team and the Community Nursing Service (Adult).

There must never be a lack of care given, and some cases will require phased and sensitive hand-over and transitional care between services. This will require discussion about the care plan with all individual involved in the child's care.

Exclusion

- Where an individual has social needs only, e.g. personal care/equipment needs.
- Administration of low molecular weight heparin (dalteparin, enoxaparin, and tinzaparin) or other subcutaneous injections for individuals who are ambulant and able to self-administer or who have carers who can administer following appropriate education by the service initiating the treatment -
- Routine management of pleurex drains for individuals who able to self-care following appropriate education by the service initiating the treatment.
- Removal of clips and sutures for ambulatory patients following planned surgery, this should be carried out by GP Practice Nursing Staff.
 - Blood tests for INRs (unless patients cannot be transported to INR clinic, [due to being housebound](#)).
 - Same day blood test requests unless they are for prevention of hospital admission or pre-treatment testing, [for housebound patients](#).
- Requests for urgent nursing need that requires an immediate response or response within 2 hours - Patients will be reviewed by their GP who then refers to the most appropriate service. The Community Nursing service will support where there is clear evidence that it will prevent an unplanned hospital admission.
- Linked to the above, requests for urgent blood tests (same day bloods) unless there is clear evidence that they will prevent an unplanned hospital admission.
- Diagnostic Doppler's for Suspected DVT - This is an unsafe procedure to carry out for patients with suspected DVT , Doppler testing should only be carried out for patients who are receiving active nursing care for management of a leg wound. Either, as a diagnostic tool or to review a non-healing wound. Patients need to be supported to attend an emergency portal for assessment of suspected embolisms.
- Continence assessments and reviews for patients with no other Community Nursing needs
- Routine catheters following discharge from hospital, patients should be taught to self-manage their catheters by the services who initiate the procedure. If this is in a hospital setting patients should be provided with the knowledge and

equipment to manage the catheter day to day and contact details of day and OOHs Community Nursing service for any problems if they are housebound only.

The Community Nursing service needs to be made aware of any housebound patient discharged from hospital with a new catheter including information on when it need to be reviewed/changed. (these are not excluded)

In managing patients within routine catheters, the Community Nursing Service will need to ensure a social needs assessment is undertaken to ensure that where patients have more specific needs these are identified to support the self-management of their catheters

- Routine 'welfare check' visits for patients who are discharged from hospital. Patients who are housebound should be provided with Community Nursing contact details and provided with information to self-care where appropriate by the hospital
- Provision of general nursing care (including syringe driver care and equipment; basic wound care; catheter care (urethral and supra-pubic) and pressure area care) to patients receiving nursing care in a registered care home. The Community Nursing Team should only be providing care for patients with complex nursing needs that is above that expected of a general nursing home nurse

3.4 Any acceptance and exclusion criteria and thresholds

The Community Nursing teams shall provide a holistic model of care following assessment however it is expected that referrals will be received and accepted for the following although not exhaustive care requirements: -

Continuing Health Care

Community Nurses will continue to work with these individuals receiving NHS Continuing Health Care on a case by case basis. Including contributing in the process of assessment for NHS Continuing Health Care with the lead CSU CHC assessment team for those patients on the community nursing caseload. This will include housebound patients who may not currently be known to the community nursing service but where there is clearly a defined primary physical health need.

The CHC checklist will be completed by the most appropriate member of the community team (this could be any health or social care professional including the community nursing team). If required, the Decision Support Tool (DST) will be co-ordinated by the most appropriate health professional i.e. the community nursing service will co-ordinate and lead the care where the patient is known to the service and has primary physical health need.

This process may include those patients whose needs do not meet the level for CHC funding but require Funded Nursing Care (FNC). The Community Nursing Team will not participate in the assessment for CHC funding, where a patient is resident in a nursing home and already has FNC in place.

Tracheostomy Care

Community Nurses will continue to work with, provide the care and management of housebound patients with tracheostomies on a case by case basis as part of a multi-disciplinary plan to accept a patient into the community with an appropriate plan and training as required.

The community nursing team will provide support for self-care and weekly changing of ribbons that secure the tracheotomy tube when patients are not able to self-care.

The changing of the main tube will not be carried out by the community nursing team due to safety risks attached to this procedure. The changing of tube should be undertaken by a consultant or consultant supervision within secondary care.

Residential Care

Where patients are living in Residential Care Homes, for whom regular travel to the GP practice is deemed clinically unfeasible, Community Nurses shall provide nursing care in consultation with the patient's GP.

Community Nurses will work with residential care home staff to support patients receiving appropriate and timely care so that patients are cared for safely as appropriate and not referred onto other services i.e. acute, undertaking nursing interventions as per other housebound patients.

Nursing Homes

The services specified within section 3.2 must be provided for housebound patients with complex nursing needs within the patients home including within nursing homes to ensure that patients are not be disadvantaged.

If clinically appropriate the Community Nursing Service shall provide clinical knowledge, training and support via work shadowing to the home have access to registered nursing staff 24 hours a day. On acceptance of the patient into the care setting, it is expected that the care will be provided by the nursing home.

- The community nursing staff will on a case by case basis provide up to two visits, giving clinical guidance to the registered staff within the care home to enable them to continue to deliver the care required to prevent the patient from becoming disadvantaged
- Where it is highlighted that the home cannot provide the care this will be escalated to the Chief Operating Officer and the CCG to resolve the issue without any risk to patient care
- The Community Nursing team is not responsible for the validation or assessing the competency of care staff employed by another provider
- The Community Nursing team cannot guarantee the provision of any ongoing equipment, this must be provided by the nursing home, this includes but is not limited to - pressure relieving equipment, dressings, prescriptions, syringe drivers
- Where it is apparent that the care home cannot provide the adequate care required by the patients a referral to Adult Safeguarding will be made to ensure no patient is disadvantaged

All Care Homes

- If a care home is accepting and being funded for a patient specifically for EOL care then the home should have the ability and equipment to deliver
- If a patient deteriorates in a care home (nursing or residential) or in own home receiving DOM care then it is reasonable to expect the Community Nursing team to support with syringe driver management if staff are not familiar with the equipment – up to 4 visits until staff can take over the care
- Provision/support with EOL care to prevent unnecessary hospital admission sits within the previous and new community nursing specification. However, if a home has specifically accepted and being funded to meet the needs of an EOL resident then they should have the appropriate skills and equipment to do so

Equality and Inclusion – Meeting Public Sector Equality Duty³

The provider will ensure that in the configuration of their services to deliver the requirements of this service specification that as a provider organisation they must consider how they will ensure that **ALL** services they provide takes into consideration the needs of **Protected and Other Disadvantaged Groups⁴⁵** as part of the **Public Sector Equalities Duty⁶** as defined by legislation and national policy, including engagement, delivery and access.

It is important to note that this is not an above and beyond to the day to day but should be embedded within practice, policies, service planning and design, making reasonable adjustments to the way services are delivered. This requires a tailored and flexible response from services, where professionals may need to work across traditional boundaries for the benefit of all patients.

For difficult to engage groups (i.e. socially excluded groups e.g. homeless, people who are drug dependent and other Inclusion Health groups), SSOTP will work with commissioners to develop and implement an outreach clinic service for these patients, through partnership working with other agencies.

Innovation and efficiency⁷

The provider is expected to support the commissioner and the delivery of this service by innovating and or developing new ways of working that support better and improved outcomes for patients and ensure that the service maximises efficiency and value for money, along with removal of non-value adding activity, supporting the introduction of new systems / procedures / policies / protocols that will benefit patients' experience & outcomes, reduce the risk of harm and increase efficiency.

3.5 Interdependence with other services/providers

Whole System Relationships

Integration with Primary Care Teams:

- The Community Nursing service shall work with GP Practices to embed local working arrangements to an agreed standard that support GPs in meeting the local needs of the practice's patients as part of the proposed MCP model
- Community Nurses shall work closely with Practice Nurses to avoid duplication and ensure that services are provided jointly where appropriate to best meet the needs of patients

³ <https://www.england.nhs.uk/about/equality/>

⁴ <http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

⁵ <https://www.legislation.gov.uk/ukpga/2010/15/contents>

⁶ <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty>

⁷ <http://www.twbstaffsandstoke.org.uk/index.php>

- The service is not expected to provide cover for Practice Nurses in the event of holidays or sickness
- The Community Nursing service shall be an integral part of the MCP team and will be based within the Community Care Hubs as a minimum and support the decision making process on how to improve the delivery of integrated care to reduce the number of unnecessary hospital admissions
- Community Nurses foster and maintain close clinical links within General Practice
- The Community Nursing Service will work towards an appropriate IT solution providing entry in a single care record

Integration with Other Community Services:

- Community Nurses shall work with other community services which form part of the extended team i.e. Heart Failure Specialist Team, Home First, Specialist Nursing, Therapy teams, Equipment teams, Fire Safety teams, etc. to ensure joined up care provision for people, through the emerging MCP Teams
- Community Nurses shall also maintain the required communications and working relationships with their relevant Home First Team to ensure oversight of patients moving from acute settings into Home First as part of a 'step up/step down' approach
- Community Nurses will deliver care by Tele-health and Tele-care as appropriate and ensure that this fits with delivery by other inter-relating teams

Collaborative working with Acute Hospitals:

- Community Nurses shall have a key role in supporting patients on their caseload to prevent avoidable admittance into acute settings
- Community Nurses will work directly with acute teams and contribute to the timely and well-coordinated discharge of patients back out of acute settings into the community if appropriate in line with Home First and D2A
- This will include liaising with acute services regarding new developments, treatments or/and equipment requirements
- Protocols must be in place with all acute hospital treating NHS patients including private providers where NHS patients have been referred and treated such as Nuffield Hospital
- A referral process must be in place with acute hospitals outside of the local health economy ('out of area') to enable the smooth transition of Northern Staffordshire patients who require the support of the community nurses following an intervention/admission

Collaborative working with Mental Health, Social Care and Voluntary Sector:

- The Community Nursing Service will work collaboratively with Mental Health, the Palliative care sector, Social Care (SOT) and the Voluntary Sector providers to ensure quality patient care which supports patients as a whole.

Collaborative working with Independent Providers:

- The Community Nursing Service will work collaboratively with independent providers, for example care homes (including nursing homes) and GP Out of Hours Services to ensure quality patient care and to ensure that patients are not disadvantaged by where they live.

Transition from Children's Community Nursing Service

- Timely proactive engagement should take place between the Children's Community Nursing Team and the Community Nursing Service. From the age of 18 or 19 for a child with learning disabilities. A referral can be made into Adult Community Nursing Team will be made. There must never be a lack of care given, and some cases will require phased and agreed with the service user in the first instance and sensitive hand-over between services. This will require discussion about the care plan with all individual involved in the child's care.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- The Provider shall adhere to appropriate national standards, eg, NICE Guidance, NICE Quality Standards, Royal College Guidelines.
- The Provider shall be obligated to review the evidence base on a continual basis to ensure compliance with good clinical practice
- Care In Local Communities: A new vision and model for District Nursing (2013) Department of Health NHS Commissioning Board
- District Nursing – Harnessing the Potential (2013) Royal College of Nursing
- Delivering Care Closer To Home: Meeting the Challenge (2008) DoH
- 20/20 Vision 5 years on. Reassessing the future of District Nursing (2014). Queens Nursing Institute. Web version 1.1
- NMC. The Code (2015). Nursing and Midwifery Council.
- NMC (2015) Standards of Proficiency for Nurse and Midwife Prescribers. Nursing and Midwifery Council

- National Quality Board (2013). How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability [online]. NHS England website. Available at: <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-toguid.pdf> (accessed on 17 October 2017).
- NHS Five Year Forward View (2014)
- <https://www.england.nhs.uk/about/equality/>
- <http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>
- <https://www.legislation.gov.uk/ukpga/2010/15/contents>
- <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty>
- <http://www.practicenurse.co.uk/index.php?p1=a-z&p2=wounds-and-wound-care>
- https://rcni.com/sites/rcn_nspace/files/ns.30.27.40.s45.pdf

4.3 Applicable local standards

- Children's and adults safeguarding policies as per Staffordshire and Stoke on Trent Safeguarding Boards.
- <http://www.twbstaffsandstoke.org.uk/index.php>

5. Applicable quality requirements and CQUIN goals

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

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Responsiveness of service including urgent, semi urgent and planned referrals	Completed report	Quarterly audit	GC9 Contract Management
Pilot to share information with GP practices – conduct a pilot within one practice with the intention of being able to share information regarding caseload and discharge.	Pilot in place by July 2018 (tbc) Evaluation report and roll out plan as appropriate September 2018 (tbc)	Pilot in place by July 2018 (tbc) Evaluation report and roll out plan as appropriate September 2018 (tbc)	GC9 Contract Management
service users receiving care report a good experience	95%	User and Carer Service user Experience Survey - 20 service users per month	GC9 Contract Management
Patient reported outcomes measure	To be agreed		
For Community Nurse caseload service users - Pneumococcal and/or Flu vaccination identified as needed	Number	Spreadsheet/RI O	GC9 Contract Management
For Community Nurse caseload service users - Pneumococcal and/or Flu vaccination accepted (administered)	Number	Spreadsheet/RI O	GC9 Contract Management
For Community Nurse caseload service users - Pneumococcal and/or Flu vaccination declined	Number	Spreadsheet/RI O	GC9 Contract Management

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Local Requirements Reported Locally				
All local reporting requirements should be split by CCG				
Number of referrals received by Community Nursing split by a) source b) reason for referral c) day d) time of day	Monthly – timeframes to be agreed for information but full implementation by 30 th November on RIO To be included within audit where appropriate	Rio	Within 15 Operational Days of the end of the month to which it relates.	
All service users to have a care plan Number of service users with a care plan - personalised directed care plan split by type of service user need • Eg : EOL, Emergency, Housebound etc. • If the care plan has been followed	Quarterly	Audit	Within 15 Operational Days of the end of the month to which it relates.	
Activity split • Number of service users on caseload • First • Follow-up • Ratio F/Fup • Where seen service users o Home o Nursing Home o Residential home o Clinic o Other reported by exception • • Length of stay • Number of service users discharged	Monthly	Rio	Within 15 Operational Days of the end of the month to which it relates.	
Number of inappropriate referrals received • by referrer and • reasons why inappropriate o incomplete referral o inappropriate referral o referred to another service • GP practices	Monthly	Rio	Within 15 Operational Days of the end of the month to which it relates.	
<u>Wound management</u> Percentage of Doppler's completed within 2 weeks of leg wound for community nursing service user cohort	Monthly	Rio	Within 15 Operational Days of the end of the month to which it relates.	

5.4 Applicable CQUIN goals (See Schedule 4 Part E)

As per Schedule 4 Part E

6. Location of Provider Premises

Each Community Nursing Team will have a base within the Community Care Hubs within North Staffordshire and Stoke on Trent as a minimum requirement of this specification.

The Community Nursing Team will undertake a review of clinic utilisation on a quarterly basis to ensure that other clinics are located to best meet the needs of the patients referred to the community nursing service including outreach within other provider or voluntary organisations.

The review of clinic utilisation must include engagement with patients who access the service and GP practices.

Any changes however must be agreed with Commissioners prior to any change being implemented. Where agreement cannot be reached, this will be escalated to the Commissioners/Providers Executive Team.

Also changes to clinic locations once agreed must be communicated to all providers, services that may refer into the Community Nursing Service.

It is also recognised that occasionally operational decisions may need to be made concerning the venue and times of clinics to ensure a safe service can be delivered.

Any previous or new remuneration agreements between GP Practices and MPFT are outside of the scope of this contract and as such must be negotiated directly between GP Practices and MPFT as appropriate.

7. Individual Service User Placement

Not applicable

Appendices

Appendix One

North Staffordshire CCG and Stoke on Trent CCG Primary Care and Community Nursing Wound Management

Introduction

The process of tissue repair or healing is extremely complex and unpredictable, particularly in older patients suffering from multiple co-morbidities and with the effects of aging on the tissues. In all cases, healing will rely on the controlled response to trauma and the intrinsic ability of the body to heal. Every patient's healing times, needs and wound are unique, which will present ever-changing challenges to the clinician.

Therefore it is important to look at wound classification and type rather than a specific timescale on when wounds should heal by. It has been estimated that the annual NHS cost of managing wounds is about £4.5-£5.1bn, after adjustment for comorbidities, with two-thirds of the cost incurred in the community and the rest in secondary care

In the main, acute surgical wounds and simple lacerations will heal without a problem in an otherwise healthy person. Acute wounds are expected to heal within an anticipated timeframe with no patient or environmental factors delaying healing. Minimal or no tissue loss allows clean, acute wounds to rapidly seal and heal.

The commonly encountered problematic wounds are those that become chronic. These include leg ulcers, pressure ulcers, diabetic foot ulcers, dehiscent wounds and any wound that is being left to heal by secondary intention. Such wounds can be identified as chronic if the underlying aetiology is diagnosed. This is essential to developing a successful care plan for optimising the patient's ability to achieve healing, as much as possible.

As wound healing is a complex multifactorial process, the input of several members of the multi-disciplinary team may be required to achieve the objectives. Evaluation is an on-going process. Each clinician involved in the provision of care must work within their Scope of Practice and is accountable for their practice.

Definitions

Mobility

Housebound - The definition of a housebound individual is as prescribed below, and is defined by capability rather than age or social circumstances : - 'People who have proven morbidity and who are unable to leave their home, either on a short term or long term basis and where there is a nursing need.'

The patient will be deemed to be housebound when they are unable to leave their home environment through a physical and/or psychological condition. In assessing whether a patient is considered housebound an assessment should be undertaken considering the nature of the treatment / surgery they have received, which may temporarily make them housebound. Housebound also includes patients within nursing homes.

Ambulatory - 'The definition of an ambulatory individual is: 'Patients who are physically able (with or without assistance) to access clinic, minor injury unit or GP Practice/Walk in Centre'.

Healing

Healing by Primary Closure - Most clean surgical wounds are managed by primary closure. The edges are approximated together, using sutures, clips or steristrips or glue following aseptic non-touch technique. Surgical wounds normally heal uneventfully when covered by an appropriate interactive dressing that provides a barrier to infection (NICE CG 74 2008). Any of these wounds that break down are then classed as healing by secondary intention.

Healing by Secondary Intention - This is when the edges of the wound are not artificially drawn together and the wound is allowed to heal through contraction and development of connective tissue. This should follow the normal healing process of Haemostasis, Inflammation, proliferation, maturation. Pathway for assessment and management of these wounds to follow the wound pathway

Tertiary healing is when the wound is left open until the risk of infection or foreign body has gone, only then can the wound be closed.

Wound - a break in the continuity of the skin

Simple wounds – high healing potential in 2-6 weeks These wounds are expected to heal quickly, the patient is well with no indications that wound healing maybe protracted. E.g. closed surgical wounds, superficial lacerations, burns or scalds.

Complex wounds – Medium healing potential in 6-12 weeks. A wound where problems and risks have been identified which may delay healing or where more complex treatment is required such as Topical Negative Pressure. E.g. open surgical wounds or where the patient presents with a medical condition that may delay healing. These cases may require specialist advice and input.

Chronic wounds – Low healing potential in 12 weeks A wound which has failed to heal or progresses slowly over 12 weeks due to a multiple of factors such as the patients underlying co-morbidities or past history becomes a chronic wound. Specialist advice and input may be required.

Non-healing wounds – very low healing potential, ongoing 26 weeks These are static wounds which may fluctuate slightly but rarely go on to heal due to underlying pathology, poor general health, multiple co-morbidities or lifestyle choices. The objective of care is palliation / prevention of symptoms such as pain, infection and malodour.

Types of wounds

- **Pressure Ulcer:** localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (EPUAP, 2010)
- **Venous Leg Ulcer (VLU):** a wound to the lower leg that fails to heal within a minimum of 4 weeks due to poor venous return
- **Arterial Leg Ulcer:** a wound to the lower leg that fails to heal within a minimum of 4 weeks due to insufficient arterial circulation
- **Mixed Aetiology Leg Ulcer:** a wound to the lower leg that fails to heal within a minimum of 4 weeks due to a combination of arterial and venous impairment
- **Rheumatoid Leg Ulcer:** a wound to the lower leg that fails to heal due to the systemic effects of rheumatic disease
- **Malignant Leg Ulcer:** a wound to the lower leg that fails to heal within a minimum of 4 weeks due to neoplasm within the wound
- **Diabetic Foot Ulcer (DFU):** a wound to the foot of a diabetic person that fails to heal due to the systemic effects of diabetes
- **Dehiscence:** the partial or complete separation of a closed surgical incision due to infection or other cause
- **Fungating wound:** a neoplasm that erupts through the skin surface
- **Fistula:** an opening between 2 organs or (more relevant to this specialty) from an organ to the skin surface - an entero-cutaneous fistula

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

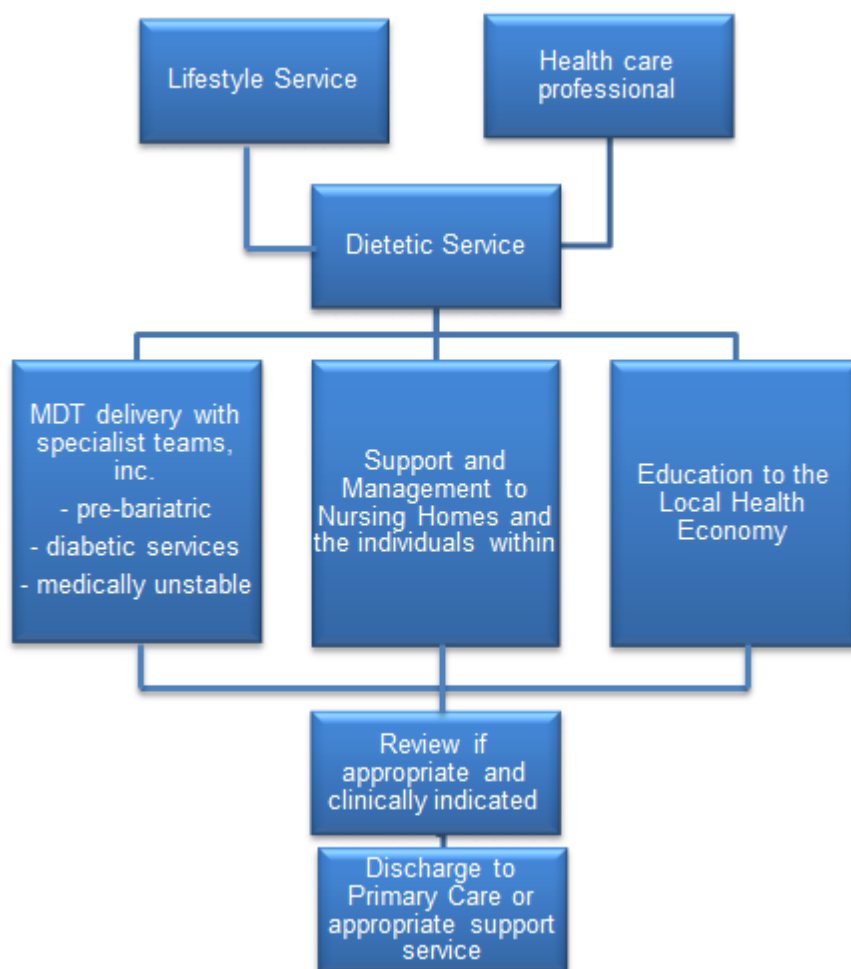
The Service shall appropriately triage referrals and ensure that where appropriate individuals are referred to the Lifestyle Service provided by Staffordshire and Stoke on Trent Partnership Trust (SSOTP);

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_20
Service	Specialist Continence Service
Commissioner Lead	Kam Gill
Provider Lead	Ian Turner
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.1 National Context and Evidence Base

The National Service Framework, Older People (2001) DoH, identifies the key components of an integrated continence service for the conservative management of urinary incontinence as:

- Identification and appropriate referral of patients (principally women, but men shall be seen in specialist clinics. Level 1 staff i.e. District Nurses shall see a full cross section of service users) with urinary and faecal incontinence.
- Initial assessment and conservative management of urinary incontinence by trained and competent staff.
- Development of high-quality integrated continence services.

All people with urinary incontinence and symptoms indicating a more complex condition should have access with a prompt referral to a specialist continence service. The population benchmark for referral into a urinary continence service is 0.80% of the adult female population per year.

Evidence Base

- National Audit of Continence Care (2010) Royal College of Physicians
- Cost effective commissioning for continence care – all Parliamentary Group for continence care report 2011
- Essence of Care (2010) DoH Benchmarks for Bladder, Bowel and Continence Care
- NSF for Long Term Conditions (2005) DoH NHS Plan (2006) DoH
- The National Service Framework (NSF) for Older People (2001) DoH
- Good Practice in the provision of Continence Services (DoH, 2000)
- NICE Clinical Guidelines Urinary Incontinence for Females (CG171, Sep 2013)
- NICE Clinical Guidelines The management of lower urinary tract symptoms in men (CG97, May 2010)
- NICE Clinical Guidelines The management of faecal incontinence in adults (CG49, Jun 2007)

2. Outcomes

2.1 NHS Outcomes Framework Domains and 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 harm

2.2 Local Defined Outcomes

1. Improved outcomes for patients i.e. quality of life as demonstrated by a survey, section 8.1.
2. Service User, carer and referrer satisfaction as demonstrated by a survey in section 8.1.
3. Promotion of conservative management and enablement of Service Users to self manage their conditions.
4. Improve Service Users self-care and prevention demonstrated through:
5. A reduction in inappropriate reliance on products for the containment of urinary/faecal incontinence wherever this is resource neutral.
6. Reduced demand for urgent care and interaction with secondary care.

7. Provision of comprehensive activity data.

3. Scope

3.1 Aims and objectives of the service

The Specialist Community Continence Service shall deliver at Level 2 for more complex conditions. The service will deliver conservative treatment to promote continence to delay or reduce the risk of service user needs escalating. As a last resort the service will provide a management strategy with the general principle being the prescription of containment products to manage bladder and bowel leakage (Level 1 basic assessments are undertaken by community staff basic assessments are to be received directly by the District Nursing teams and those for complex patients to the Specialist Community Continence Service). The service shall provide for adults resident in South Staffordshire with complex conditions.

- To promote continence wherever possible with an emphasis on prevention and the reduced need for access to secondary care.
- To ensure that patients access high quality care and management methods to assist in the maintenance of quality of life, independence and personal dignity.
- To comprehensively assess, diagnose and treat service users.
- To effectively treat and resolve an individual's urinary and/or faecal incontinence with an emphasis on cure rather than containment being the principle aim.
- To ensure that service users are fully informed about their care and participate in shared decision making.
- To provide a treatment plan that includes conservative management and self-care.
- To provide resources to improve patient education, promote independence and self- management of continence needs.
- To maintain individuals' independence in daily living activities through active treatment and management strategies.
- To arrange onward referrals where clinically necessary.
- To undertake joint assessments as part of a multi-disciplinary team to negate the need for multiple appointments e.g. one stop clinics within the acute.
- To increase continence service capacity and patient access to support.

3.2 Service description/care pathway

The Specialist Community Continence Service shall be delivered in the community in accordance with evidence based practice for service users with bladder and bowel problems. The service shall work to the integrated care pathways (Refer to Appendices) developed with health care partners across South Staffordshire. The Service shall be accessible Monday to Friday, 9.00 am – 17.00 pm, Monday to Friday, 52 weeks per year excluding bank holidays.

The service shall provide

- Flexible appointments to support more urgent demand or unplanned care. Patients referred who require more urgent treatment shall be contacted within three working days to arrange an appointment and will be seen within two working weeks. These patients are not patients who are in acute retention of urine.
- Relevant and timely signposting.
- A face to face assessment with appropriate clinical diagnosis, interventions and advice.
- Expert knowledge and specialist advice to other professionals e.g. General Practitioners, Community Nurses, Health Visitors, Learning Disability Nurses, Social Services, School Health Advisers to promote good practice.
- Physiotherapy
- Public education and awareness of incontinence to break down barriers which prevent people from presenting with continence problems.
- To provide decision aids and access to resources to support individuals to manage their incontinence, promoting self-care.

In addition, the Specialist Community Continence Service shall

- Manage the Home Delivery Service and procurement for continence management products.
- Manage the supply of continence containment products ensuring a needs led, cost effective assessment and delivery process and product provision which is high quality, timely and cost effective. Products shall be provided to adults and children, including those individuals with learning disabilities.
- Work closely with acute trusts when re-tendering the procurement of continence products and reviewing the urology continence formulary to ensure economies of scale/consistency in provision
- Monitor and control costs for product expenditure within the budget to include the provision of continence products from assessing health professionals e.g. Link Nurses.
- The allocation of products shall be set at a maximum of three products per day, from the formulary,

unless the clinical needs indicates otherwise

The Specialist Community Continence Service shall

- Work in an integrated manner with service providers across primary and secondary healthcare and social care in relation to specialist pathways. The Service shall participate in multi-disciplinary meetings with secondary care bladder and bowel specialists for the purposes of reviewing and agreeing a co-ordinated approach to the care of high risk patients.
- Work closely with other services for adults, e.g. learning disabilities, stroke, parkinsons nurses in order to maintain appropriate standards of continence care.
- Deliver preventative health promotion with allied disciplines such as tissue viability, falls prevention, older people's care teams and community nursing teams.

3.3 Population covered

The service shall be provided to all service users registered with a General Practitioner in the following Clinical Commissioning Group (CCG); Cannock Chase, Stafford and Surrounds and South East and Seisdon Peninsula for whom the Commissioners are responsible for funding healthcare services.

3.4 Referral pathway acceptance, exclusion criteria and thresholds Referral sources

An open referral system shall be provided. Referrals shall be accepted from a patient's registered GP, community service, or self-referral for reviews in line with the integrated pathways, a medication list and past medical history, and if necessary a completed bladder and catheter diary.

Self referrals shall be received from individuals who have previously used the service and require review/reassessment. Where self-referral occurs and the patient consents, a medication list and past medical history shall be requested from the patient's GP within 3 working days of referral.

There shall be an effective referral route into the service for complex patients and mechanisms to track these patients. Referrals shall be accepted electronically, or in writing, by telephone or face to face contact. The appropriateness of the referral shall be evaluated by the Specialist Community Continence Service based on the inclusion/exclusion criteria prior to an appointment being offered. If the criteria are not met the referral shall be signposted to an appropriate service. The service shall feedback inappropriate referrals to the commissioners.

The standard response time and prioritisation is 4 weeks for all service users with the exception of these that require more urgent treatment when the response is 2 weeks.

Inclusion criteria

- Adults, aged 18 or over
- Experiencing bladder and/or bowel problems
- Stress urinary incontinence
- Overactive bladder
- Urge urinary incontinence
- Passive urinary incontinence
- Functional incontinence
- Inappropriate voiding
- Difficulty during urination
- Nocturia
- Adult Nocturnal Enuresis
- Aids to manage incontinence
- Flow tests
- Faecal incontinence in the absence of other pathology
- Prolapse – Grade I, II and Grade III & IV for individuals not wanting surgery
- Pregnancy related urinary symptoms

Exclusion Criteria

- Adults, under the age of 18
- Haematuria (frank, microscopic or Dipstick)
- Palpable bladder
- Abdominal or pelvic mass
- Recurrent Urinary Tract Infection – more than 3 in 1 year for females and more than 1 for males plus unusual organism

- Neuropathic bladder
- Suspected fistula
- Previous pelvic irradiation
- Incontinence associated with pain
- Non-compliant patients, or for non-attendees at appointments (Patients who Do Not Attend (DNA) on two consecutive occasions must be discharged from the service and their GP informed). The Commissioner does not pay for DNAs.
- Red flags *refer to pathways*

Onward referrals (not an exhaustive list)

- General Practitioners
- Physiotherapy Service
- Occupational Therapy
- Secondary Care; Continence Nurse/Consultant
- Nursing Homes - Lead Continence Nurse Specialist, NHS Continuing Healthcare

It is the responsibility of the Specialist Community Continence Service to ensure that referrers are clear about the criteria and mechanisms to refer into the service. Information shall be sent to GPs and other potential referrers to include information requirements, full detail and patient profile, to process the referral in a timely manner. The Provider shall ensure that the information is up to date and circulated regularly.

The Specialist Community Continence Service shall establish whether the patient is able to attend the preferred option of a community clinic, or requires a specialist home visit based on the service users clinical need. Patients shall be contacted by phone, letter, email or fax to be offered an assessment.

Assessment

Referral to the Specialist Community Continence Service shall occur when Level 1 treatments are unsuccessful, or the individual presents with complex problems requiring an advanced clinical assessment by a competent Specialist Continence Adviser (A bladder scan may form part of the assessment process)

Prescription

The Specialist Community Continence Service shall ensure common standards across link nurses and shall frequently monitor requisitions for continence products to assure appropriate provision for patients. Standard minimum response times shall be maintained for Service User prescriptions to delivery of containment products e.g. 12 week delivery cycles to ensure value for money. End of life patients shall receive 4 week cycles. The delivery cycle may be extended to 16 weeks where possible. In order to help reduce stock piling patients in their own homes shall be on a 'self-care' system and be required to make a telephone call to the home delivery service to initiate each order or postpone if the patient wishes. Products other than those on the approved list may be supplied if there is a proven clinical need and this is agreed by the Continence Nurse. Submission to the Continence Nurse of a completed assessment form with documentation explaining patients need is essential.

Review/Reassessment

The Specialist Community Continence Service shall review complex patients as per the attached urinary continence pathways. Self-referral for a review/re-assessment can be made.

Where required, continence products for complex patients shall be prescribed and reviewed after 1 year, unless the patient's condition may benefit from earlier review, for example at the planned progress review as per the attached pathways.

A proactive approach to reviewing patients shall be undertaken by the Specialist Community Continence Service and link nurses; including District Nurses who undertake initial patient assessments. Service users shall be reviewed/reassessed depending on their individual needs, taking into account treatment, management and their care plan to achieve care goals. Ongoing reassessment shall be documented for each patient to include changes in continence status and reassessment dates. Contact details of the assessor shall be available to the service user and carer.

Continuation of supplies shall be dependent upon reassessment being undertaken on the annual review date.

Once the service user have optimised treatment and achieved maximum outcomes the Specialist Community Continence Service will refer the service user to community nursing.

Care Pathway

The clinical pathways are presented in the appendices to this service specification. The Specialist Community Continence Service shall interface seamlessly with referring GPs and secondary care to ensure direct and unencumbered patient pathways.

Patients information/Self care

The Provider shall produce leaflets and signposting information for patients as required. This information shall be made readily available in GP practices, clinic locations and across the whole system organisations. Patients or carers can be provided with this written information if the Provider is contacted for information prior to the decision to refer. All written patient literature shall be current and up to date with appropriate copyright acknowledgements. Patients and/or carers must be provided with contact numbers for the Continence Service should they require any further information or advice pre or post discharge.

3.3 Interdependence with other services/providers

The provider shall work with the following organisations to deliver services

- Local General Practitioners (GPs)
- Local NHS Community Service providers including Tissue Viability, Community Nurses, Occupational Therapists, Physiotherapists, Rehabilitation teams, Moving and Handling and other specialist services
- Intermediate Care Teams
- Continuing Care services
- Community Services e.g. Rehabilitation, Respiratory

4. Applicable Service Standards

4.1 Applicable National Standards (eg NICE)

- NICE CG 171 The management of urinary incontinence in women
- NICE CG 49 Faecal incontinence in Adults
- NICE CG 97 Lower urinary tract symptoms (LUTS) in men

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

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (see schedule 4 parts A-D)

Schedule 4 C Local Quality Requirements

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach
Service User experience Baseline Standard validated measure of Quality of Life (NICE guidance) are included in the continence assessment and review of treatment effects.	Initial questionnaire: to establish the baseline for Continence Service patients Discharge questionnaire: post 6 months treatment to evidence impact of intervention Inclusion of the Friends & Family Test Service User reported improved quality of life indicators pre and post treatment to demonstrate improvement / cure rate / effectiveness of clinical outcomes Commissioners require a sample of service users, approx. 30-40 p.a.	>95%	Quarterly Management Report	Contract Clauses 13/14
Maintaining Quality of continence assessments	Continence Service to review a sample of District Nursing assessments for products	>95%	Annual report to include: - Audit on quality of completed	Contract Clauses 13/14

undertaken by District Nurse	Commissioners require review of District Nursing assessments sample size approx. 30- 40 p.a.		initial Level 1 assessments by District Nurses and outcomes and associated action plan.	
Outcome of conservative management techniques, where identified as part of their treatment plan	Number of pelvic floor exercises for men and women commenced by Continence Nurse Specialist/Women's Health Physio	>95%	Data report - quarterly	Contract Clauses 13/14

Schedule 6 A – Activity Reporting Requirements

Activity

- Number of referrals received by referral source e.g. GP, community nurse, self-referral.
- Number of referrals rejected and reasons why.
- % of referrals referred onto secondary care.
- Reduction in avoidable secondary care attendances – where identified.
- Referral to assessment wait times.
- Number of referrals seen and by diagnosis.
- Waiting time from containment product order to delivery - delivery contained within the 18 weeks RTT timeframe.
- Number of reviews carried out.
- New:follow up ratio.
- Number of Service Users seen by different staff group and location.
- Number and % of Service Users requiring > 3 follow-up appointments/contacts.
- Number of Service Users cured, treated or symptoms alleviated whilst within the service or post discharge.
- Number of Service Users self managing to agreed treatment plan at 9 months.
- DNA rates.
- Discharge rates.
- All untoward user safety incidents and subsequent improvements in practice implemented.
- Incidents and near miss reporting.
- Compliments, Complaints and outcomes.
- Workforce data; sickness levels, use of bank/agency staff, turnover, mandatory training compliance and improvements made.

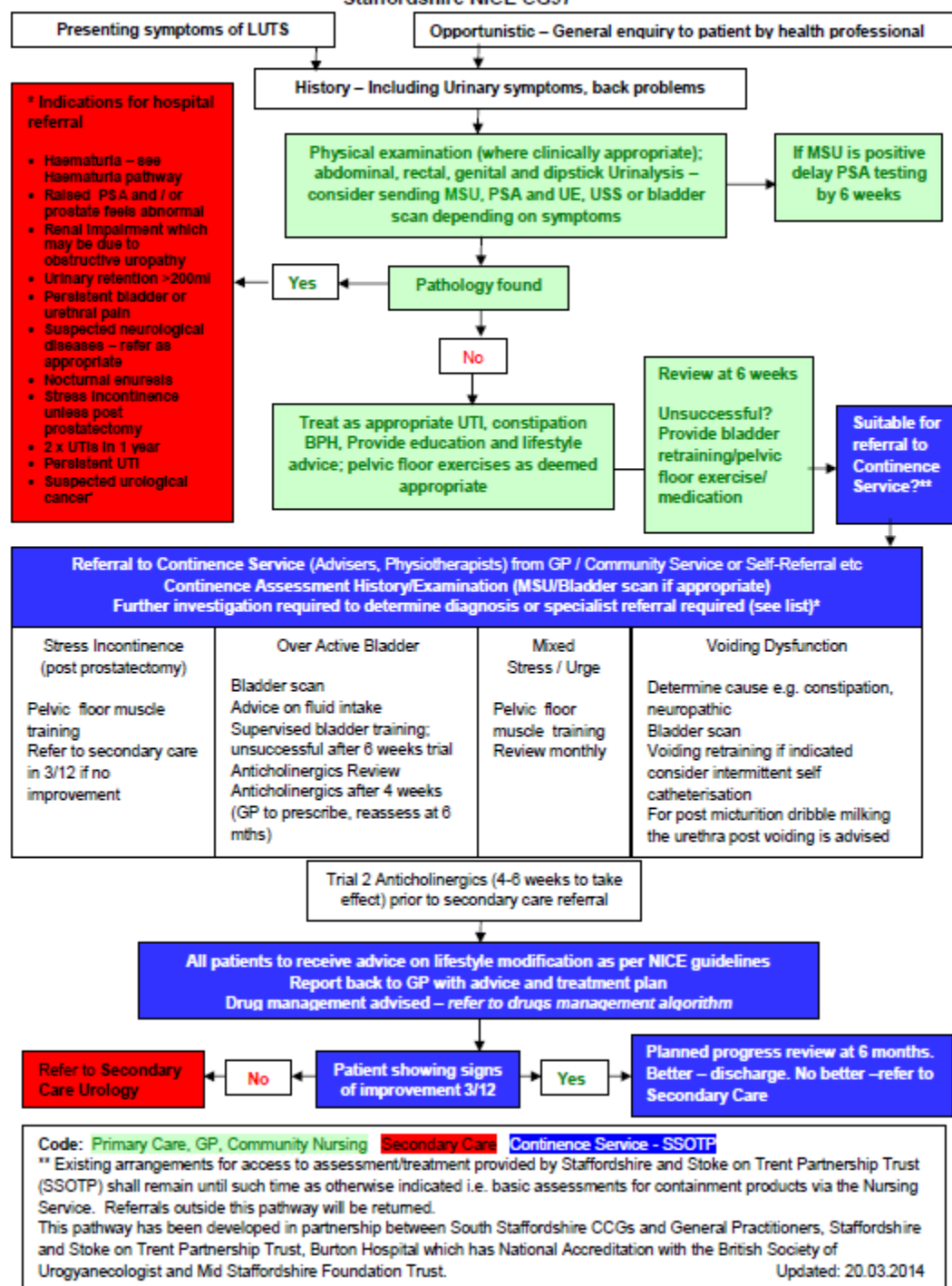
5.2 Applicable CQUIN goals (See schedule 4 Part E)

6. Location of Provider Premises

The Provider premises are located at: Stafford, Cannock and Rugeley.

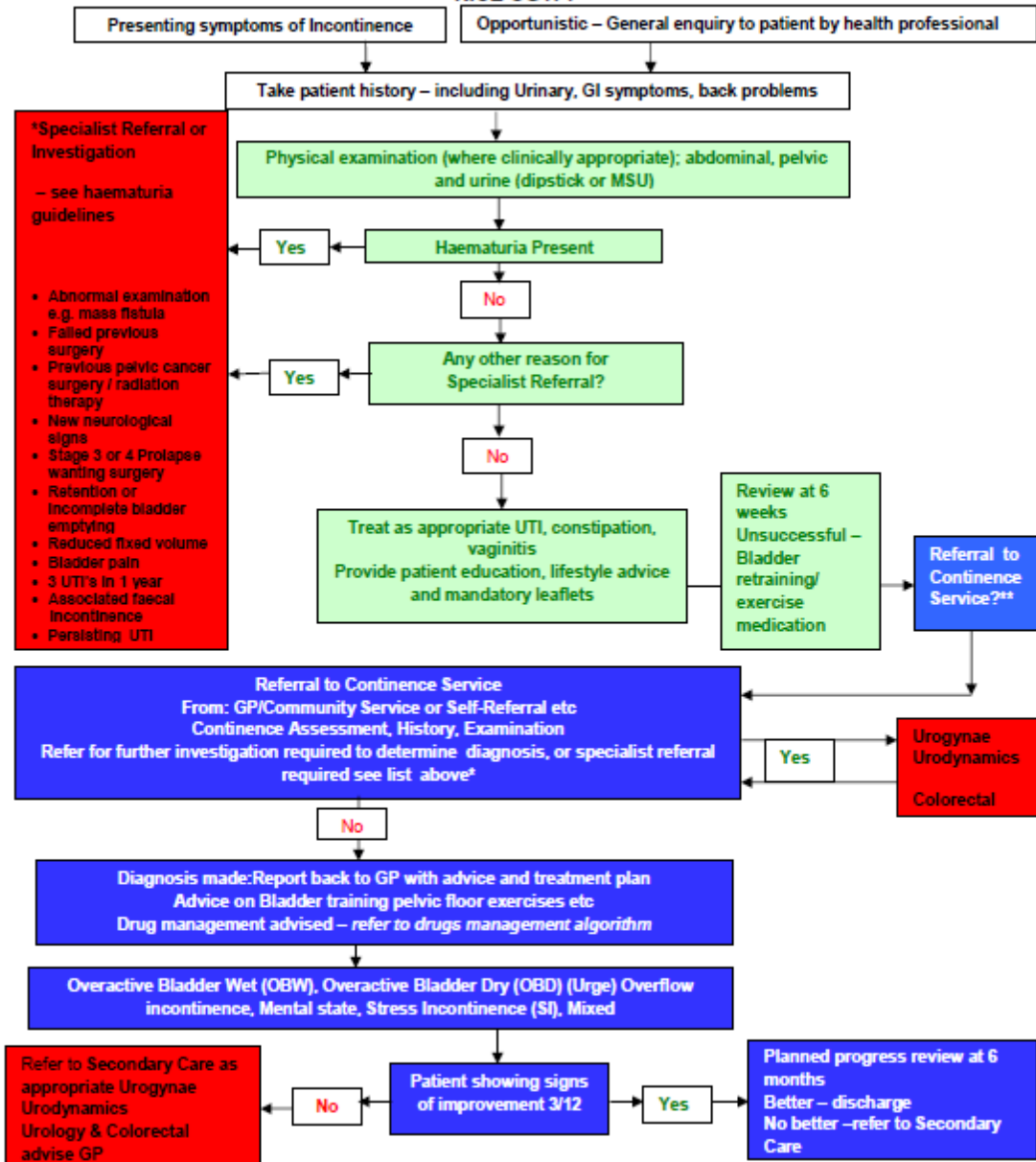
7. Individual Service User Placement

**Appendix One: Male Urinary Continence & LUTS Integrated Pathway South
Staffordshire NICE CG97**



Appendix Two: Female Urinary Continence - Integrated Pathway South Staffordshire

NICE CG171



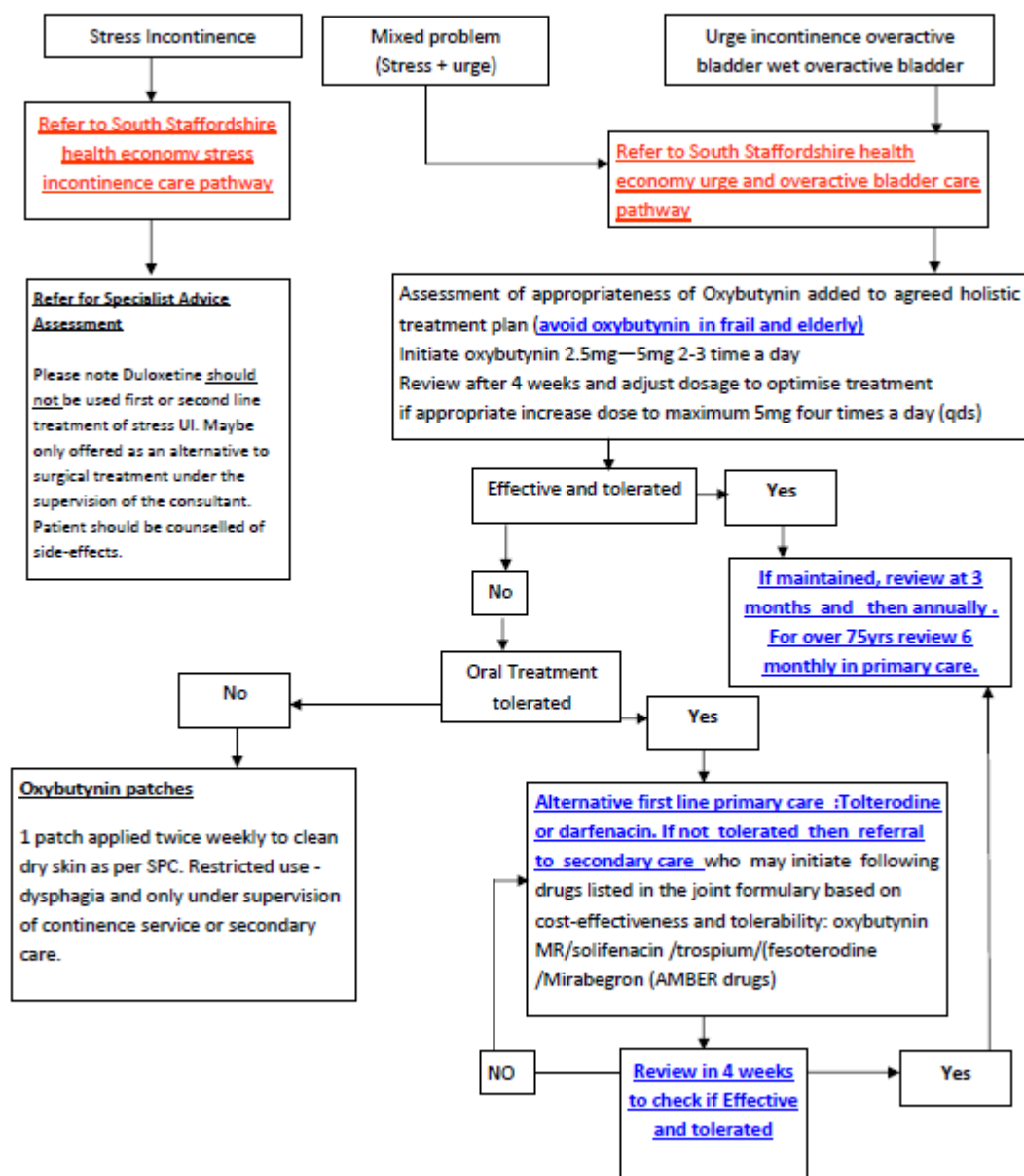
Code: Primary Care, GP or Community Nursing Secondary Care Continence Service - SSOTP

** Existing arrangements for access to assessment/treatment provided by Staffordshire and Stoke on Trent Partnership Trust (SSOTP) shall remain until such time as otherwise indicated. Pessary fitting arrangements remain as current. Referrals outside this pathway will be returned.

This pathway has been developed in partnership between South Staffordshire CCGs and General Practitioners, Staffordshire and Stoke on Trent Partnership Trust, Burton Hospital which has National Accreditation with the British Society of Urogynaecologist and Mid Staffordshire Foundation Trust.

Updated: 20.03.2014

Appendix 3 – Algorithm for Medicines for Urinary Incontinence – February 2014



Service Specification no.	CS_021
Service	Children's Speech & Language Therapy Services

Population and/or geography to be served	1.0 Population covered The service will be available to children and young people aged 0-19 years of age (includes those with an EHCP up to the day of their 25th birthday) and who are registered with a GP within the geographical boundaries of Staffordshire and Stoke on Trent and excluding East Staffordshire CCG area.
Service aims and desired outcomes	2.0 Local defined outcomes 2.0.1 The service will contribute to the outcomes identified within the collaborative partnership of Staffordshire's Children and Young People and Families Strategy 2016, that children and young people will be: • Happy and healthy • Feel safe and belong • Achieve and contribute 2.0.2 The strategy prioritises: • Starting Well - every child has the best possible start in life to reduce difference in the quality of people's health and wellbeing in the future. • Growing Well - children and young people are supported to reach their potential so that they can have greater control over their lives. • Learning Well - children, young people and adults are supported to make good lifestyle choices. 2.0.3 The particular benefits to CYP in receipt of SLT and support may not become evident for many years but may include: • Improved communication skills • Improved language skills • Reduced social isolation and social exclusion for children • Reduced behavioural difficulties and increased independence • Increased potential to access National Curriculum by the children • Increased education attainment and progress by the children • Increased employment opportunities in the future • Improved self-esteem for the children • Reduced involvement with the criminal justice system • Increased independence 2.0.4 In addition, the service will share skills with parents, carers and education providers surrounding speech, language, communication and feeding needs associated with an individual's needs. 2.1 Aims and objectives

	2.1.1 The aim of the Speech and Language Therapy (SLT) Service is to support and achieve better outcomes for Children and Young people (CYP) with speech, language, communication and feeding needs using a child, young person and family centred approach. 2.1.2 This aim will be achieved by implementing the following objectives: • Using speech and language therapists who are Allied Health Professionals registered with the Health and Care Professions Council, uniquely trained and qualified to assess and diagnose speech, language, communication and feeding difficulties and who identify interventions which can alleviate or resolve these difficulties. • The service will provide a functional and needs-led assessment for CYP speech, language, communication and feeding needs in a timely and appropriate manner according to 18-week national guidance. The service will accommodate: – Dysphagia referrals within 2 weeks – Speech, Language and Communication referrals within 8 weeks • The service will deliver assessments and interventions in the most appropriate and accessible functional setting for the child, young person and their family (this is most likely to be a health centre, educational/Early Years settings or home). • The service will deliver SLT management plans and interventions that have a functional impact and are outcome focused, with individual outcome measures for each CYP. • The speech and language therapy service will provide interventions that are evidence based and clinically safe, effective and efficient, and consistent with national and local policy, clinical guidelines and NHS Standards. • The service will co-work with the wider workforce and work in partnership with specialist SLT including those in secondary acute care providers, educational settings and third sector providers. • The service will ensure waiting times for assessment and delivery of service adhere to national guidance and best practice which include 18-week referral to treatment guidelines and Dysphagia guidelines. • The service will demonstrate an equitable spread of capacity based on CYP's need and will vary the distribution of capacity in response to assessed patterns of demand across each CCG area. • The SLT service will support CYP's transition to adult services. • The service will provide skill sharing and therapy strategies for parents, carers and key individuals to enable them to support the child/young person with SLCN or feeding needs. • The service will work with protocols to manage referrals including the stage pathway tool kit and locally agreed standard operating procedures, to support and provide intervention, ensuring efficient use of resources while paying due regard to ensuring equality of access for CYP.

	The service will contribute and support Early Help Assessments and Educational Health Care Plans.
Service description and location(s) from which it will be delivered	3.0 Service Description - The Speech and Language Therapy service will provide child, young person and family-centred services that recognise and build upon strengths and focus upon improving outcomes. - Following referral acceptance, all CYP are assessed, and then profiled by a speech and language therapist to urgent or routine categories. - In addition, following initial assessment the CYP will be risk assessed using the North Staffordshire Risk Matrix (NSRM). - The principles of the North Staffordshire Risk Matrix are that a decision to offer therapy is based on two key measures: - The impact of the speech, language, communication or feeding impairment on CYP, over and above that which would be expected at their general level of learning and development. This means that although CYP may not have the speech, language and communication functional ability typically expected of CYP of their age, their skills and abilities may be in line with their general learning and cognitive development, i.e., exactly what would be expected at their stage of development. - The likelihood of a positive outcome from Speech and Language Therapy, in other words the capacity of CYP to benefit from the service SLT uniquely provides. This is important because the majority of CYP would benefit from any targeted intervention and/or extra attention from a trained speech and language professional. - If CYP receive a score of 4 or below using the risk matrix following assessment, they will not be offered an appointment but will be provided with advice and referred to other appropriate services if applicable. - Following each episode of care an individual's response to the intervention is assessed and profiled again using the NSRM. This may lead to alternative packages of care being considered or a discharge from SLT as the CYP will no longer benefit from what SLT can uniquely offer. - Parents, educational setting advisors and early year's settings will be recognised as key partners in delivering effective SLT and feeding services. Training, advice, skill sharing, and support will be provided to these partners to assist the effectiveness in meeting the speech, language, communication and feeding needs for an individual child. - CYP whose needs can be met by universal or targeted services and are low risk are not offered direct therapy. Instead, these CYP will be signposted for support into universal/targeted services or offered advice only. Parents and Carers will also be offered advice at this stage if appropriate. This model ensures that only CYP with a specific need for

therapeutic intervention receive a specialist service. Intervention is underpinned by care plans and outcome measures.

- The service will usually operate from weekdays 09:00 to 17:00; however, in significant circumstances this may require negotiation with Educators, Commissioners and Providers to meet the needs of a CYP.
- Total available capacity should be used flexibly and transparently with the provider working alongside the commissioners to agree figures.
- The service must manage caseloads and co-ordinate care, discharging and referring on CYP as appropriate.

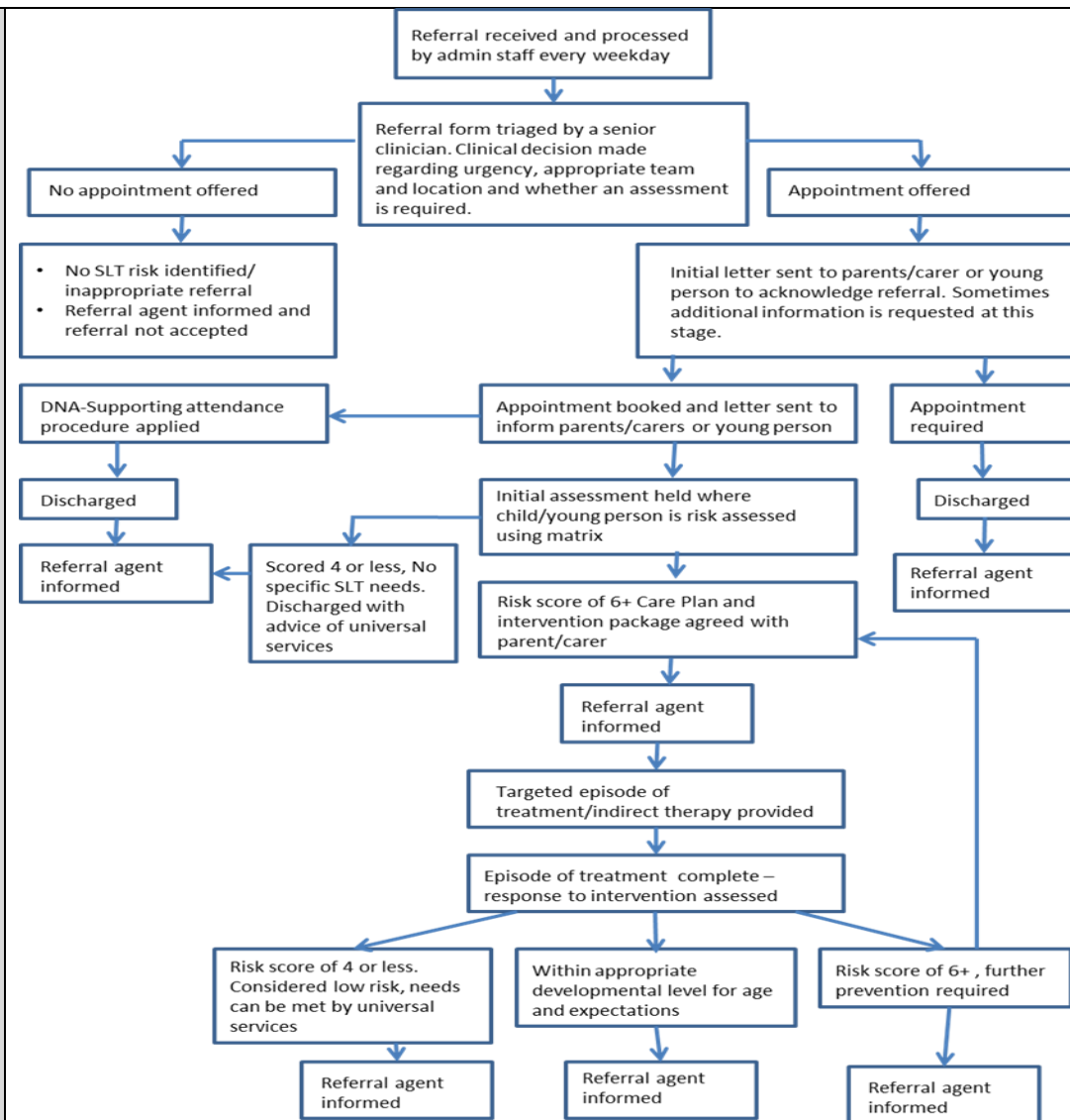
3.1 Referral Pathways

3.1.1 The service offers an open referral system using a standardised referral form which outlines the minimum information required to support clinical triage and decision making. Changes within the referral form will be circulated to relevant healthcare professionals, educational providers and commissioners, while referral guidelines are available within the staged pathway toolkit.

3.1.2 Referral forms are completed and sent to the SLT service via:

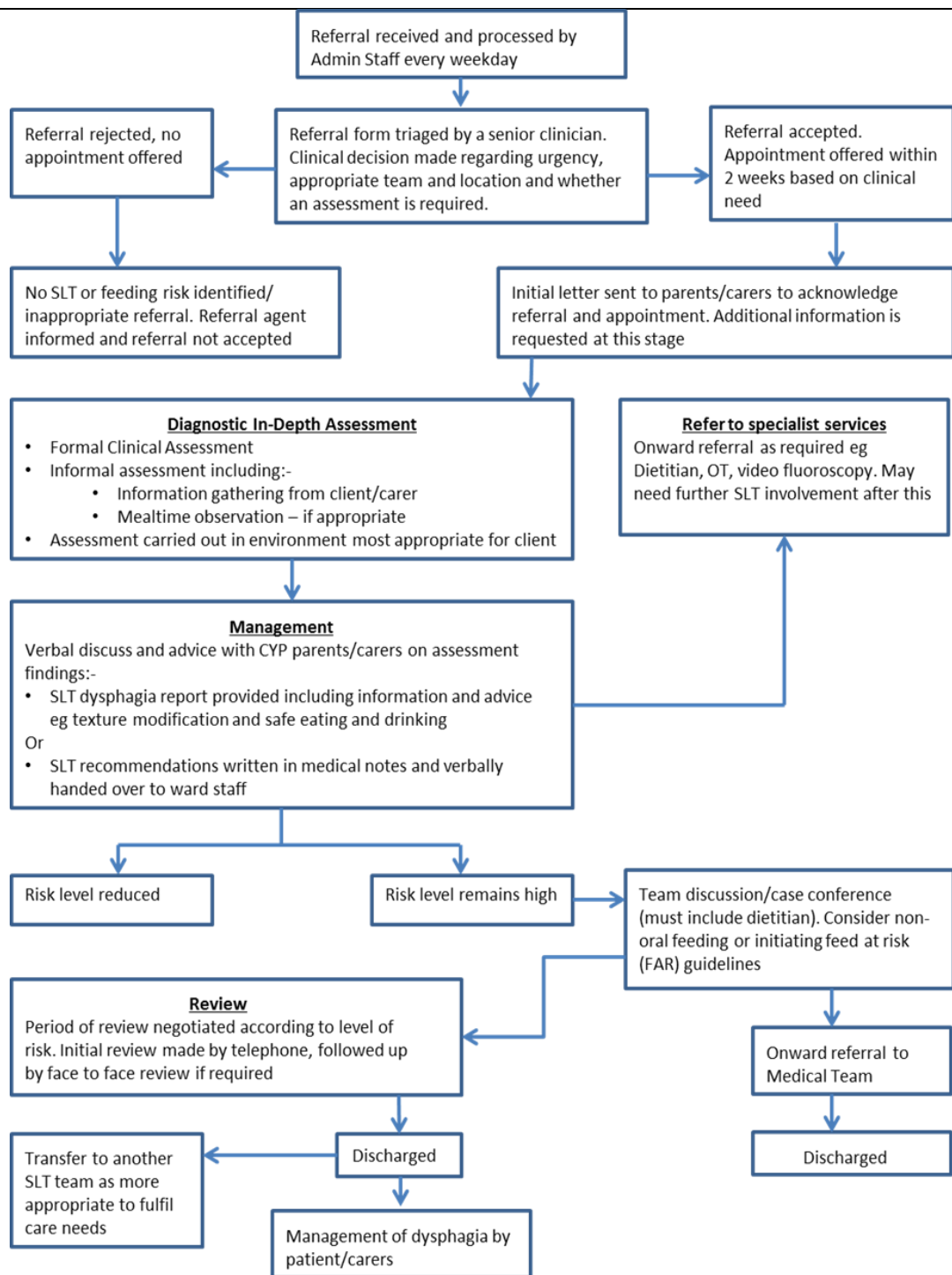
- Post
- Secure Email
- Phone

3.1.3 General Care Pathway for Communication needs:

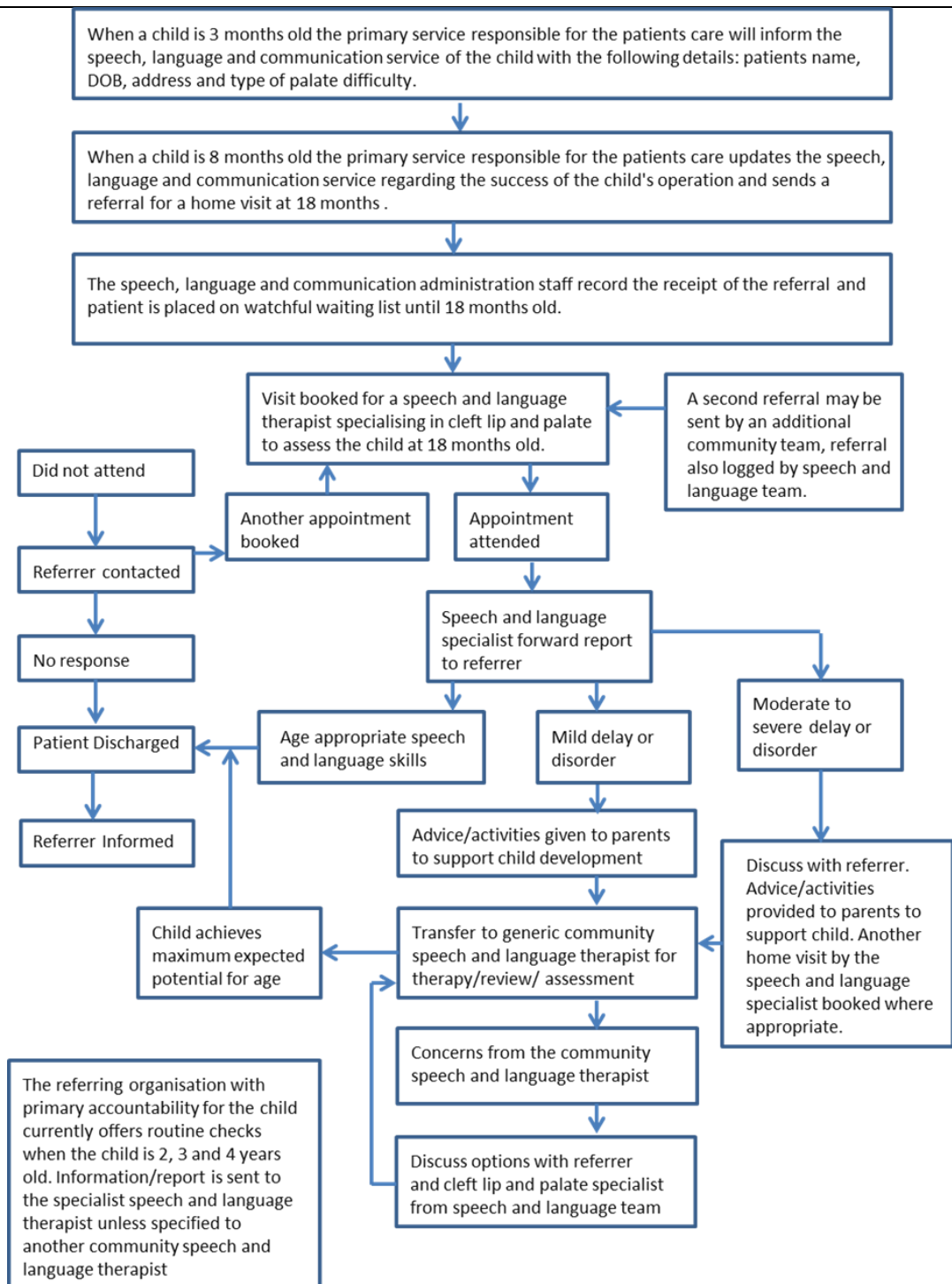


3.1.4 There are specific pathways for dysphagia and Cleft Lip and Cleft Palate:

Care Pathway – DYSPHAGIA



Care Pathway - Cleft Lip and Cleft Palate



3.2 Referral Criteria

The Speech, Language, Communication and Feeding service includes specialist assessment and intervention for children and young people with the following needs:

- Language Delay
- Language Disorder
- Phonological Delay
- Phonological Disorder
- Speech Delay
- Speech Disorder
- Communication Disorder
- Swallowing and Feeding Difficulties
- Dysfluency
- Voice Disorders
- Craniofacial and velopharyngeal disorders (cleft palate and related disorders)
- Deafness or hearing impairment

The SLT service operates an open access referral system allowing referrals to be submitted by:

- Children and Young People
- Parents and Carers
- GP's
- Health Visitors
- School Nurses
- Acute and Community Paediatric health services
- Education providers and early years settings
- Children's Social care and Preventative Services
- Police
- Youth Offending Services
- CAMHS teams
- Not excluding others
- CYP 0-19 years can access the service. In some circumstances the service can be extended for users up 25 years where there is a complex health need, Special Educational Need or Disability and/or an Educational Health Care Plan noting SLCN and no identified team has been recognised to meet the needs of the CYP. A plan for transition would however be in place.
- Incomplete referral forms, or forms with limited detail, will be returned to the referrer unless in exceptionally urgent circumstances.
- Referrals that do not meet the referral criteria will be recorded and redirected to the most appropriate service.
- Referrals will only be accepted for CYP registered with a GP in Staffordshire. The service will follow organisational policy and guidance regarding gaining appropriate consent for referrals.

3.3 Assessment

The community speech and language therapy service will:

- Provide functional, needs-led assessment for the identification of children and young people's speech, language and communication needs.
- Provide clear feedback to CYP, parents, carers, the referring agent and the child or young person's educational setting. This should include the assessment outcome, functional goals agreed, the recommended intervention, management advice and guidance and information about training available.
- Deliver assessment in the most appropriate and accessible functional context for the CYP.

3.4 Intervention

The community speech and language therapy service will:

- Deliver interventions that have functional impact that are outcome focussed, with outcome measures agreed for each CYP.
- Deliver interventions that are evidence based.
- Deliver interventions that are flexible and accessible and build upon the strengths of the CYP.
- Share skills with parents, carers and educational staff to enable them to contribute to the effective delivery of interventions.

3.5 Care Plans

- Following the assessment an individual Care Plan is required to monitor and evaluate programs of care.
- The plan must be robust involving the CYP, family and/or carers and multi-agency partners if necessary.

3.6 Evaluation

The community speech and language therapy service will:

- Evaluate the achievement of agreed functional outcome measures for each CYP.
- Use outcome measures evaluation data to drive continuous service improvement.
- Participate in national and local evaluation and research.

- Seek patient/user and parent/carer feedback.

3.7 Transition

The community speech and language therapy service will:

- Assist to facilitate the transition from paediatric services to adult services making use of national tools, for example Ready Steady Go documents.
- Assist CYP to transition within educational settings.

3.8 Response times and prioritisation

The community speech and language therapy service will accommodate:

- Referral to treatment time – 8 weeks for communication referrals
- Referral to treatment time – 2 weeks for community dysphagia

3.9 Safeguarding

The community children's speech and language therapy service will:

- Work to national safeguarding policies, procedures and guidance and to local Staffordshire Locality Safeguarding Children's Board (LSCB) policies, procedures and guidance.
- Be aware of potential indicators of abuse or neglect and to signpost or refer as appropriate and to implement the Stoke on Trent or Staffordshire Safeguarding Children Board's "Safeguarding Children and Adults at Risk of Abuse or Neglect Policy and Procedure" as appropriate.
- Be aware of and understand the Stoke on Trent or Staffordshire Safeguarding Children Board's "Early Help Strategy" and implement the use of the "Early Help Tools".
- All speech and language therapists will be trained in safeguarding to level 3.

3.10 Skills Development

- Externally-
 - Provide and support skill sharing for families, staff and partner agencies on speech, language, communication and feeding skills required to support CYP with specific needs identified by the SLT team.
 - Training and information sharing will be provided to external organisations to improve early identification of needs and improved quality of referrals.
- Internally-
 - Ensure all staff receive regular supervision. This can be received through a combination of group and individual supervision

sessions. Supervision should be aligned to role responsibilities and needs of service users and their families.

- Ensure all staff undertake all mandatory training requirements, including safeguarding, equality and diversity.
- Ensure that all staff receive appropriate up to date training to enable them to utilise all equipment appropriately.
- Ensure that the workforce is able to meet the needs of the service.

3.11 Commissioning SLT Community Services

The service will work alongside CCGs and the local authority to develop services aimed at extending the effectiveness and cohesiveness of local health and social care provision.

3.12 Personal Healthcare Budgets

Following the mandate from NHS England regarding the provision of Personal Healthcare Budgets (PHBs) for individuals who may benefit from this offer; where possible, the service will support the CYP and their family/carers to pursue a personal healthcare budget. If a personal healthcare budget is requested by CYP and their family/carers the service should support and assist their decision making and pursuit of alternative treatment where possible. Providers will collaborate with CCGs to provide an option of a PHB and this should be done at a scale and pace that meets local need and resources. PHBs can be offered in a number of ways either as a notional budget; third party or a direct payment or a combination of the three.

3.13 Acceptance criteria and thresholds

All referrals are clinically triaged, and a decision made as to whether intervention is appropriate or not.

- The service will be available to children and young people aged 0-18 years of age (includes those up to 19 in full time education) and who are registered with a GP in the geographical boundaries of Staffordshire.
- A risk score of 6 and above on the North Staffordshire Risk Matrix.

3.14 Exclusion criteria and thresholds

Exclusion Criteria for the service includes:

- CYP not registered with a Staffordshire GP
- CYP who do not have a clinical profile of above 4 on the NSRM (for example where a child's speech and language are delayed but are in line with cognitive skills).
- Behavioural feeding difficulties.

- Primary selective Mutism in isolation.
- Primary literacy difficulties e.g. specific learning disability.
- CYP receiving packages of care by other providers that conflict with evidence-based intervention delivered by the SLT service.
- Complex Augmentative and Alternative Communication Needs.
- Providing assessment on request for CYP who receive assessments from another agency/organisation.
- Primary communication need for CYP is English as a second language.

3.15 Interdependencies with other services/providers

SLT works with many partners including:

- Children, young people and their families, parents/carers
- Families First
- Early Years Forum
- Staffordshire and Stoke on Trent's Safeguarding Boards and operational teams
- Stoke Speaks Out
- Voluntary agencies
- Health Visiting Service/0-19 service
- Education providers
- GP
- Acute Trusts
- School Nurse Service
- Special School Nursing Service
- Community Paediatricians
- CAMHS
- Audiology
- Social Work Teams
- Childcare
- Entrust
- Independent providers
- Child Development Centre
- Other Allied Healthcare Professionals e.g Dietitians, Occupational Therapists, Physiotherapists

3.16 Applicable national standards

- The provider must comply with all the relevant policy and legal compliance and guidance, including but not limited to:
- Relevant NICE guidelines
- Human Rights Act 1998
- Equality Act 2010
- Health Act 199 and 2006
- Health Bill 2009
- Health and Social Care Act 2012
- Care Standards Act 2014

- Healthy lives, brighter futures – The Strategy for children and young people's health, DH/DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services DH (2006)
- Transition: getting it right for young people
- NHS at Home: Community Children's Nursing Services (2011)
- The National Service Framework for Long-term Conditions, DH (2005)
- Commissioning Children and Young Peoples Palliative Care Services, DH (2005)
- NSF for Children, Young People and Maternity Services., DH (2004)
- Disabled Children and Young People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- DH (2003) Getting it right: National Service Framework for Children. Standards for Hospital Services.
- Working Together to Safeguard Children (2013)
- Children's Act (2004)
- Facing the Future: Together for child health (RCPCH, 2015)
- The future for community children's nursing: challenges and opportunities (RCN, 2014)
- RCN Children's Community Nursing Promoting Effective team working for children and their families (2003)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)
- The service will ensure that they are registered, and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with The Special Educational Needs and Disability code of practice 0-25 years.

3.17 Applicable standards set out in guidelines and /or issued by a competent body (eg Royal Colleges):

- Royal College of Speech and Language Therapists Clinical Guidelines 2005
- Royal College of Speech and Language Therapy Clinical Guidelines <http://www.rcslt.org/>
- Royal College of Speech and Language Therapists position statements www.rcslt.org
- Health& Care Professionas Council standards of proficieny for speech and language therapists. <https://www.hcpc->

[uk.org/resources/standards/standards-of-proficiency-speech-and-language-therapists/](http://www.hpc-uk.org/resources/standards/standards-of-proficiency-speech-and-language-therapists/)

- Health Care Professions Standards of conduct, performance and ethics –<http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics>
- Ready Steady Go guidelines surrounding the transition between paediatric and adult services

3.18 Applicable local standards

3.18.1 Primary, secondary and community services should continue to work closely together and meet regularly to review clinical practice and share best practice initiatives.

3.18.2 The service will contribute to the outcomes identified within the collaborative partnership of Staffordshire's Children and Young People and Families Strategy 2016, that children and young people will be:

- Starting well
- Growing well
- Living Well
- Happy and healthy
- Safe and belongs
- Achieves and contributes

The SLT service will be expected to comply with all internal organisational procedures, policies and practices.

3.19 Applicable quality requirements

Follow NICE Guidance

3.20 Applicable CQUIN goals

N/A

3.21 Location of Provider Premises

The following are the primary locations for SLT teams, however if they change the service will notify commissioner.

- Cannock and Rugeley: Block C Beecroft Court, off Beecroft Road, Cannock, WS11 1JP
- Tamworth and Lichfield: Greenhill Health Centre, Church Street, Lichfield, WS13 6JL
- Stafford and South Staffordshire: Stafford Central Clinic, 2nd Floor Civic Offices, Riverside, Stafford, ST16 3QA

- North Staffordshire and Stoke On Trent: Bentilee Neighbourhood Centre, Dawlish Drive, Bentilee, Stoke-on-Trent. ST2 0EU

4.0 Local Quality Requirements and Reporting Requirements

All data must be produced per ICB

Local Quality Requirement	Indicator	Threshold	Method of Measurement	Consequence of Breach
Proactive management of referrals to ensure patients access services promptly.	Response time within 18 weeks from referral to treatment as per National Guidelines. Graph showing response times met containing clear narrative if not met including reasons why unachieved.	95%	Monthly reporting	General Condition 9 applies
Proactive management of referrals to ensure patients access services promptly.	The service will see all urgent and Dysphagia patients within two weeks from receipt of referral while providing routine appointments within 8 weeks from receipt of referral. Graph showing response times met containing clear narrative if not met including reasons why unachieved.	90%	Monthly reporting	General Condition 9 applies

All data must be produced per ICB

Local Quality Requirement	Indicator	Threshold	Method of Measurement	Consequence of Breach
Proactive management of referrals to ensure patients access services promptly.	Response time within 18 weeks from referral to treatment as per National Guidelines. Graph showing response times met containing clear narrative if not met	95%	Monthly reporting	General Condition 9 applies

		including reasons why unachieved.					
	Proactive management of referrals to ensure patients access services promptly.	The service will see all urgent and Dysphagia patients within two weeks from receipt of referral while providing routine appointments within 8 weeks from receipt of referral. Graph showing response times met containing clear narrative if not met including reasons why unachieved.	90%	Monthly reporting	General Condition 9 applies		
	Proactive management of treatment and care plans.	Access to treatment following initial assessment offered within 8 weeks. Graph showing response times met containing clear narrative if not met including reasons why unachieved.	90%	Monthly reporting	General Condition 9 applies		
	Proactively managing clinical based outcome measures of CYP progress during treatment.	Using the East Kent Outcome System (EKOS), or Care Aims number of CYP recognised to have achieved each outcome target level. Data collected demonstrated in graph format	70-80% of CYP mostly/fully achieve	Monthly reporting (Data currently unreported however this is being addressed.)	General Condition 9 applies		
	Proactively learning from feedback provided by Children and Young People.	Every child and young person has the opportunity to participate in the Friends and Family Test Methods of collecting data: Friends and Family Tests	90% CYP would recommend	Monthly reporting	General Condition 9 applies		
	Proactively learning from Feedback provided by Families/carers	All who interact with the service who support a CYP have the opportunity to feedback on their experience.	There is no threshold requirement for this indicator as it	Monthly reporting	General Condition 9 applies		

	s or anyone supporting child or young person		is feedback on the user's experience.				
	Local Reporting Requirement	Indicator	Threshold	Method of Measurement			
	Caseload activity	Number of children and young people on total caseload on 1 day of the month. Graph grouped by age range 0-5 6-11 12-16 17-19 19+	No target Baseline Data	Monthly reporting			
	Caseload activity	Primary group is the reason for Referral. Graph grouped according to the following categories: Language Delay Language Disorder Phonological Delay Phonological Disorder Speech Delay Speech Disorder Communication Disorder Swallowing and Feeding Difficulties Dysfluency Voice Disorders	No target Baseline Data	Monthly reporting			

	Caseload activity (Further detail)	Caseload complexity profiling. This must be linked to all activity agreed, noting the North Staffordshire Risk Matrix scores of CYP. <table><tr><th>Description</th><th>Risk matrix score</th><th>Therapy time</th></tr><tr><td>mild</td><td>1 - 4</td><td>Up to 4 hours</td></tr><tr><td>moderate</td><td>6 - 8</td><td>Up to 12 hours</td></tr><tr><td>significant</td><td>9 - 12</td><td>Up to 24 hours</td></tr><tr><td>severe</td><td>16</td><td>Up to 48 hours</td></tr></table>	Description	Risk matrix score	Therapy time	mild	1 - 4	Up to 4 hours	moderate	6 - 8	Up to 12 hours	significant	9 - 12	Up to 24 hours	severe	16	Up to 48 hours	No target Baseline Data	Monthly reporting
	Description	Risk matrix score	Therapy time																
	mild	1 - 4	Up to 4 hours																
	moderate	6 - 8	Up to 12 hours																
significant	9 - 12	Up to 24 hours																	
severe	16	Up to 48 hours																	
	Caseload activity (further detail)	Range of contact methods recorded (New, Follow up, Telephone, Home or educational setting visit, other). Graph demonstrating number of contacts for each category.	No target baseline data	Monthly reporting															
	Training the wider workforce	The wider workforce receives training to support appropriate referrals No. of training sessions delivered and No. of attendees No. of Competency assessments completed (new and refresher)	No target Baseline Data	Quarterly reporting															

Service Specification No.	CS_22
Service	Community Specialist Diabetes Service
Commissioner Lead	Simon Runnett
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	
1.3 National/local context and evidence base	
Background Diabetes is a long-term condition caused by too much glucose in the blood. There are two main types of diabetes, Type 1 diabetes and Type 2 diabetes. 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. In addition, there are other less common forms. Many of the service requirements for T1DM and T2DM will overlap. In other elements each disease will require discrete service provision; where the service requirements differ between the two diseases this will be made explicit in the following document.	
1.2 National context and evidence base	
Diabetes care is one of the major challenges facing the NHS in the coming years and the quality of care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year¹ and the number of people in the UK with diabetes is increasing and is projected to rise from 3.1 million to 3.8 million by 2020². Due to the increasing obesity levels in the UK it is expected that the incidence of T2DM (which accounts for approximately 90% of diabetes in the UK³) will increase and as a result it is estimated the number of people with diabetes in the UK will rise to 4.6 million by 2030⁴. This makes it the long term condition with the fastest rising prevalence⁴. If diabetes is not managed properly it can lead to serious life-threatening and life-limiting complications, such as blindness and stroke. An individual may also have diabetes and any other number of other long-term conditions, like, for example, chronic obstructive pulmonary disease (COPD). The NHS needs to rise to the challenge of multi-morbidity through proactive and comprehensive disease management, placing the individual firmly in the centre of their care. This sort of effective management of individuals, as described in this service specification, will impact positively on indicators across the five domains of the NHS Outcomes Framework (see below). Diabetes care in the UK has improved significantly over the past 15 years^{5, 6} and the levels of premature mortality in the UK are lower than in 18 other wealthy countries⁵. In spite of these developments there is still room to improve the service delivery. Currently, only around one in five people with diabetes are achieving all 3 of the recommended standards for glucose control, blood pressure and cholesterol². Moreover, the complications relating to diabetes are wide reaching, including: • The most common reason for renal dialysis and the second most common cause of blindness in people of working age^{4,7} • Increases the risk of cardiovascular disease (heart attacks, strokes) by two to four times⁸ • Increases the risk of chronic kidney disease, from an incidence of 5-10% in the general population to between 18% and 30% in people with diabetes⁴ • Results in almost 100 amputations each week, many of which are avoidable (approximately 8 out of 10 of these)⁹	
1.4 Local context	
Stafford and Surrounds and Cannock Chase CCGs have produced a Long Term Conditions Strategy for 2013-18. It is intended to inform individuals, families and carers with a Long Term Condition registered with a GP practice in Cannock	

Chase (CC) CCG or Stafford and Surrounds (SAS) CCG. The strategy outlines the CCGs' vision over five years and describes an integrated model of care for patients with one or more Long Term Conditions, of which Diabetes is one.

As you can see from the figures below, Diabetes prevalence in England is 6.4% of the total population, with only Stafford and Surrounds having a level just slightly under this level (6.3%). It should 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+) 2014/15*

Stafford and Surrounds CCG:	6.3%
Cannock Chase CCG:	7.2%
SES&SP CCG:	6.6%
England:	6.4%

*it should be noted that there is significant variation at practice level

The Staffordshire Health and Wellbeing Intelligence group have produced a report in November 2015 on Diabetes Prevention. In this report it 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. 10

The biggest gain in reducing or delaying the onset of Diabetes and other long-term conditions are through reductions in the mean population body mass index (BMI). Local data suggests that excess body weight is the most prevalent risk factor across Staffordshire and Stoke-on-Trent. 10

The NHS Diabetes Prevention Programme is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, an evidence based behavioural programme to support people to reduce their risk of developing Type 2 Diabetes. Staffordshire and Stoke-on-Trent CCGs and local authorities have recently expressed an interest to become first wave implementers of the national programme. 10

Poorly controlled Diabetes can result in unplanned hospital admissions which is usually not desired from a patient perspective, but also has a financial impact on NHS resources. The financial impact on unplanned hospital admissions is outlined in Appendix 1 over the last three years, both for Type 1 and Type 2 Diabetes.

National Diabetes Audit

In September 2015 the National Diabetes Inpatient Audit was conducted in acute hospitals across England and Wales – Please see Appendix 1. This audit provides a reflection of the total population / prevalence rates as it is about the number of patients with Diabetes, no matter what condition or reason they were admitted for:

- The audit identified 199 in-patients with diabetes at University Hospitals of North Midlands (UHNM) NHS Trust (including some Stafford and Surrounds patients). This was equal to 17.1% of beds audited, which places UHNM in Quartile 3.
- At Russells Hall Hospital in Dudley (including Seisdon patients) the audit identified 115 in-patients with diabetes. This was equal to 18.1% of beds audited, which places Russells Hall in Quartile 3.
- For New Cross Hospital, Wolverhampton (including Cannock Chase and Seisdon patients) the audit identified 118 in-patients with diabetes, equating to 19.7% beds audited, which places New Cross in Quartile 4.
- For Walsall Manor Hospital (including Cannock Chase patients) the audit identified 98 in-patients with diabetes, equating to 22.4% beds audited, which places Walsall Manor in Quartile 4.

England prevalence for 2015 was at 16.6%, indicating that all hospitals supporting our patients have a higher than average rate of people with diabetes as in-patients.

Better control of Diabetes across our patient population could lead to a reduction in these hospital admissions in the future.

Appendix 2 outlines the results from the National Diabetes Audit from a primary care perspective.

Commissioning for Value Packs 2016

Right Care, in partnership with NHS England and Public Health England, have produced Commissioning for Value packs which illustrate how well individual CCGs are doing compared to their peers, similar 10 other CCGs (based on similar population demography and geographies). The graphs in Appendix 3 describes where each CCG is doing well and also highlights key areas for improvement.

Clinical Commissioning Group Patient Engagement

Diabetes On-line Survey The Diabetes Online Survey was open for a month, up until 11 July 2016 and was based around the fifteen essential health checks and services that patients should receive (Appendix 5). Three patient engagement

sessions were also held during this time. Of the 118 responders to the on-line survey, 82% were from Stafford and Surrounds, 8.5% from Cannock Chase and 9.5% Seisdon. Of all the responders, 77% had Type II Diabetes and 20% had Type I Diabetes. The key points from the survey are captured in Appendix 6.

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 2009: Key statistics on diabetes, Diabetes UK, 2009
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. Murray, Christopher JL, et al. (2013) UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet*
6. Lind, M., et al. (2013) Mortality trends in patients with and without diabetes in Ontario, Canada and the UK from 1996 to 2009: a population-based study. *Diabetologia*: 1-8
7. State of the Nation, England - Diabetes UK, 2012
8. Stamler J, Vaccaro O, Neaton J, Wentworth D. (1993) Diabetes, other risk factors, and 12-yr cardiovascular mortality for men screened in the multiple risk factor intervention trial *Diabetes Care*
9. Best Practice for commissioning diabetes services: a integrated care framework – Diabetes UK, 2013
10. 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 Aspirational aims

This service specification outlines the CCGs' strategic aim to achieve good patient-centred, integrated diabetes care. Some of the people diagnosed with diabetes can struggle to get care that meets their needs or swift access to specialist care when they need it.

Currently there is variation at general practice level that impacts on the capacity of the CNS/Community Consultant to see the most complex patients. We need to focus on upskilling Primary Care to provide a minimum standard of care to enable the specialist service to focus on the more complex patients (see Appendix 8). Achieving this aspiration will not happen overnight, however we cannot afford to delay implementation.

The care pathway detailed within this service specification articulates the strategic direction for Diabetes care and outlines the roles of the differing providers whether these be primary care, community care, or hospital care. The ultimate goal is to have a seamless care pathway with the patient at the centre.

The care pathway outlines the shared responsibility for all providers that deliver care anywhere along the pathway for diabetes. Rather than episodic care where a provider may have responsibility for one consultation, we want to get clinicians to have a shared responsibility for the clinical outcomes across the patch and crossing institutional boundaries, so everyone is pulling in the same direction to meet the aspirations of NICE quality standards and improve patient outcomes. The plan on how to achieve these aspirational aims and to deliver an integrated pathway is detailed in Appendix 7.

2.3 Local defined outcomes

- Provide high quality Diabetes care, as defined by NICE Quality Standard (QS6), to all patients
- To encourage Diabetes patients to see their GP for their annual checks.
- Personalised care planning to be undertaken on at least an annual basis, empowering patients to better self-manage
- Consultant-led and Diabetes Specialist Nurse-led outreach to support primary care management
- Patients to receive the majority of their care delivered in a community based setting closer to home

3. Scope

3.1 Aims and objectives of service

NICE have produced a Quality Standard to help describe what constitutes high quality care for people with diabetes. This was updated in August 2016 <https://www.nice.org.uk/guidance/QS6/chapter/Update-information>. This service specification integrates this standard into pathways of care for people with diabetes with the aim of improving outcomes. The GP will have ultimate responsibility for the coordination of patient care including agreeing when specialist input is required. Appendix 8 outlines the minimum standards for Primary Care to be achieved over the next year. The Provider will play a key role in supporting Primary care in upskilling and training Practice Nurses and GPs.

The Provider will:

- deliver high quality diabetes care, as defined by NICE Quality Standard (QS6), to all patients
- offer a holistic approach to the management of diabetes for all patients, including referral and access to other services such as Dietetics, Podiatry etc.
- through personalised care planning, empower patients to self-manage their own diabetes
- reduce the number of years of life lost for patients with diabetes
- reduce the risk of complications for patients with diabetes
- reduce duplication and gaps in the current diabetes service provision with a step-up, step-down model and improved access to information and advice
- deliver a person-centred approach
- increase the rates of access to psychological therapies/ mental health/ emotional wellbeing support, for Diabetes patients with identified mental health issues such as anxiety and depression

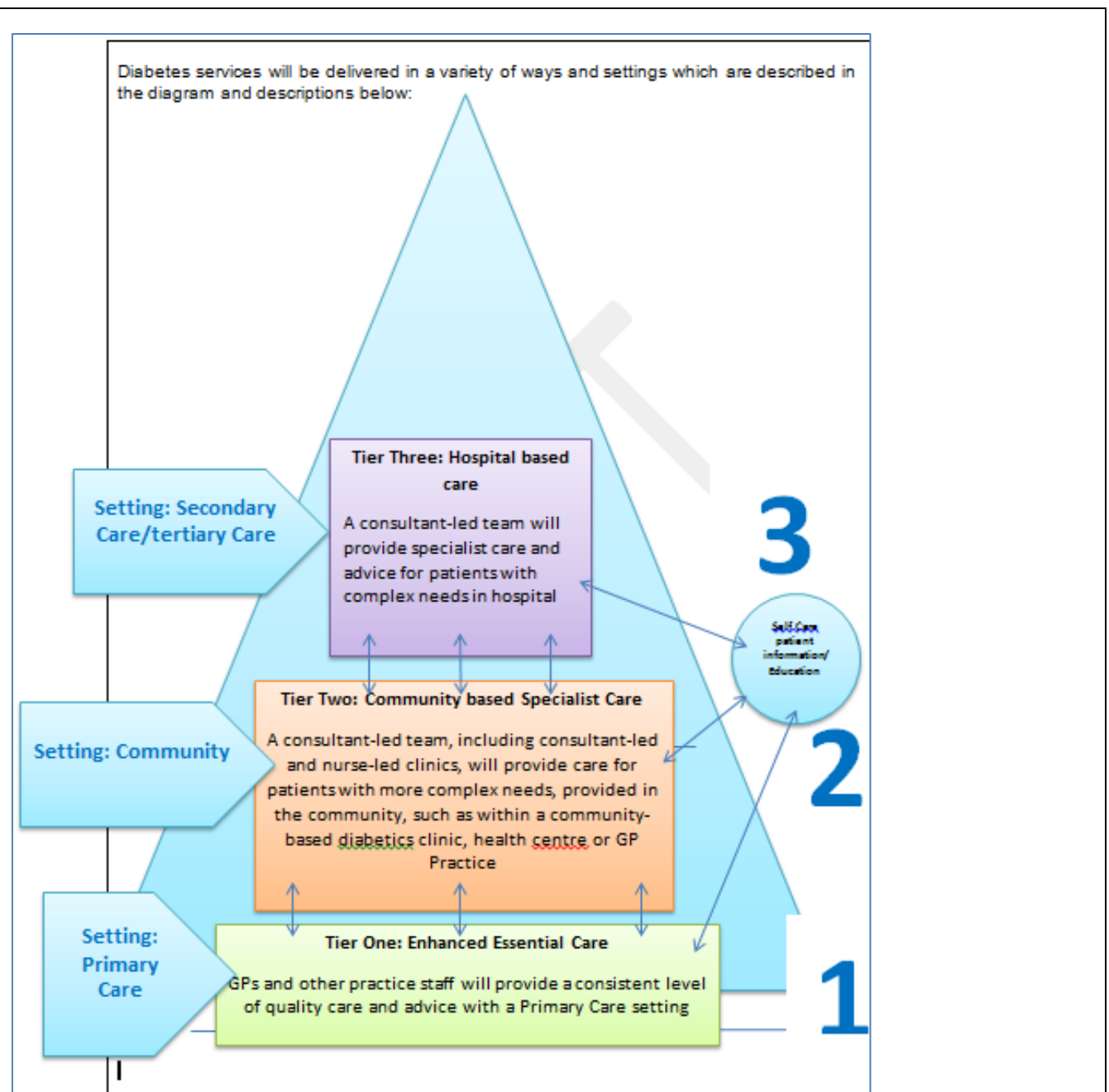
In order to provide an effective patient-focused service, the Provider shall:

- Ensure patients are provided with full access to all elements of the pathway when clinically appropriate.
- Ensure clinical staff are competent, qualified and/or trained in diabetes care (see: General Condition 5 of the Contract)
- Offer information at the time of referral to enable patients to make informed decisions regarding care and requirements.
- Offer support, information and scheduled reassessments at the time of first assessment.
- Give on-going support where required.
- Deliver a responsive service that addresses patients' needs, provides service support and demonstrates that feedback is acted on and informs improved service delivery
- Deliver a responsive service that regularly partakes in audit within and across all care settings, reviews data and uses it to inform and stimulate improvements in service delivery
- Provide information and education (in addition to the formal structured education courses) for patients in a variety of settings to promote self-management of their Diabetes
- Support the development and use of an integrated diabetes care record, located on the GP Practice IT system
- Establish Diabetes peer support group(s), to be held monthly (to be reviewed as the group develops), to enable greater patient self-management. This could be developed in partnership with voluntary sector organisations. It is intended that in the future this group would become self-sustaining.
- Offer a Diabetes helpline and email address for professionals when seeking urgent advice on management of diabetic patients
- Advise patients to access sources of information and support via Diabetes UK <https://www.diabetes.org.uk/>

3.2 Service description/care pathway

The service model of care for diabetes across Cannock and Stafford & Surrounds is reliant on the seamless integration of primary, community-based and secondary care. The model will ensure equity of services regardless of where the patient lives.

The diagram below describes how Diabetes Services will be delivered in a variety of ways and settings by primary, community-based and secondary care. A full description of the pathway and the descriptors for all partners delivering the pathway is detailed in Appendix 9.



Setting 2: Community

The Community Specialist Diabetes Service Provider will:

- ensure fast and responsive treatment of all patients with Diabetes (including nursing home and residential home patients), by standardising patient pathways and ensuring consistently high standards of care (Urgent – within 2 days of referral (working days only)s, Routine – within 6 weeks of referral (working days only)).
- support partnership between primary, community-based and intermediate care to ensure that patients are appropriately managed in the most appropriate setting.
- provide seamless care between primary, secondary and community-based care.
- contribute to MDTs where required for diabetic patients (this could be by telephone conference call).
- promote the use of patient held records ('Patient Knows Best')/ a patient portal covering diabetes care
- consider referral, where appropriate, into the obesity pathway.

The Community Specialist Diabetes Service includes a Consultant Diabetologist and Diabetes Specialist Nurses, with access to Dietician and Podiatrist.

The Community Specialist Diabetes Service Provider will deliver:

- Management of Type 1 and Type 2 patients with complex problems
- A service to improve glycaemic control for patients with Type 2 Diabetes whose glycaemic control is poor despite best efforts with self-management and in Primary Care
- Specialist Type 1 Diabetes care
- Accessible Type 1 Patient Education via an accredited programme (in line with NICE Guidance)
- Accessible Type 2 Patient Education via an accredited programme (in line with NICE Guidance)
- Bite-size tasters sessions (2 hours) to promote greater take-up of the Type 2 Patient Education accredited programme
- Advise General Practice regarding health and risk factor management e.g. hypertension, lipids
- Communication and joint working across primary care and secondary care specialist Diabetes services
- Insulin initiation and ongoing management through provision of an insulin pump service
- Education and support to primary care in the management of people with Diabetes including support to Practice Nurses. This could be through mentoring support to, and upskilling of, Practice Nurses and GPs in their knowledge and management of Diabetes and via annual Protected Learning Time sessions for GPs and Practice Nurses. Support should be targeted on poorly performing practices (which can be identified by reviewing primary care data).
- Follow-up and advice for patients post discharge from secondary care.
- The facilitation of peer support to patients with Diabetes. This will be through the establishment of Diabetes peer support group(s) to enable greater patient self-management. It is intended that in the future this group would become self-sustaining.
- Exploratory tests, which may include requesting patient blood tests. In some cases, this may be undertaken by Primary Care with the results available via the shared electronic care record.

In addition to the above the **Consultant** will:

- provide clinical leadership and support to the Community Specialist Diabetes Service
- provide leadership and support to the Diabetes Specialist Nurses
- deliver the service at clinics held in community locations, to support the most complex patients, where their needs cannot be met by the Diabetes Specialist Nurses
- step patients down to be supported by the Diabetes Specialist Nurses when appropriate
- step patients up to hospital based care where required

In addition to the above, **Diabetes Specialist Nurses** will

- deliver services in the community using a variety of clinic locations and GP surgeries where appropriate
- step patients up to the Consultant where the patients' needs regarding their Diabetes becomes more complex
- step patients down to primary care where their needs can be met there, with monitoring via annual review
- provide mentorship and support to GP Practice via the Practice Nurse and GPs, focusing on where skills and understanding could be enhanced
- deliver accessible Type 1 Patient Education via an accredited programme, at times and venues appropriate to patients. This should be offered to all appropriate newly diagnosed patients within 9 months of diagnosis. It should also be offered to all pre-existing patients with Type 1 Diabetes who have not previously partaken in structured education.
- deliver accessible Type 2 Patient Education via an accredited programme, at times and venues appropriate to patients. This should be offered to all newly diagnosed patients within 9 months of diagnosis. It should also be offered to all pre-existing patients with Type 2 Diabetes who have not previously partaken in structured education. deliver bite-size tasters sessions (2 hours) to promote greater take-up of the Type 2 Patient Education accredited programme

Patients information/Self care

The Provider shall produce leaflets and signposting information for patients. This information shall be made readily available in GP practices, clinic locations and must be available on-line and linked to Map of Medicines, for easy access for General Practice. Patients or carers should be provided with this written information where appropriate. All written patient literature must be current and up to date with appropriate copyright acknowledgements, and any information should be reviewed annually.

Diabetes UK have an on-line Guide to Diabetes <https://www.diabetes.org.uk/Guide-to-diabetes/> which offers a wealth of information and advice to support patients in managing and living with diabetes, which can also be requested via their website as hard copies. Patients should be signposted to this information through their leaflets and resources and via Map of Medicine.

Patients and/or carers must be provided with contact numbers should they require any further information or advice pre or post discharge.

Other support services

Other community services are available to support patients with their Diabetes, such as Podiatry, Dietetics, Adult Weight Management, Eye Screening, Tissue Viability services etc. The Provider will ensure that patients are referred to these services where appropriate.

Days of Service Delivery

Service to be available Monday to Friday over 52 weeks of the year. It is expected that some patient education sessions will be delivered by the Provider outside of Monday to Friday 9am-5pm office hours to enable wider access.

3.3 Population covered

The service shall be provided to all patients registered with a General Practitioner in the following: Cannock Chase, Stafford and Surrounds only, for whom the Commissioners are responsible for funding healthcare services.

Patients registered with a General Practitioner in South East Staffordshire are excluded from this service specification.

3.4 Any acceptance and exclusion criteria and thresholds

Inclusion criteria

- Adults, aged 18 or over
- Recurrent episodes of hypoglycaemia
- Insulin initiation unless provided by accredited insulin initiator in General Practice
- Sub-optimal glycaemic control HBA1c>8.0% (IFCC 64) on at least 2 maximum tolerated oral hypoglycaemic agents
- Sub-optimal glycaemic control on insulin therapy HBA1c>8.0% (IFCC 69)
- Consideration for GLP-1, as per NICE criteria
- Following recent hospital admission with Diabetes related issues
- Patients across Cannock Chase, Stafford and Surrounds

Exclusion Criteria

- Ante and post-natal care for patients with diabetes
- Gestational diabetes, pregnancy and pre-conceptual care in those that already have diabetes
- Long term complications e.g. renal and vascular complications
- Children and young people (under the age of 18)
- Management of an eGFR below 30mmols/min – refer as NICE guidance
- Emergency situations (DKA)
- Management of active complications such as acute foot problems (refer to foot pathway)
- Continuous blood glucose monitoring
- In-patient care
- Patients registered with a General Practitioner in South East Staffordshire are excluded
- Islet cell transplantation services, pancreas transplantation services, insulin-resistant diabetes services, congenital hyperinsulinism services, Alstrom Syndrome services, Bardet-Biedl Syndromes services and Wolfram Syndrome services. These are commissioned by NHS England and are delivered by tertiary centres that specialise in these specific conditions
- Ophthalmology
- Retinopathy (currently commissioned by NHS England and provided for Pan-Staffordshire & Stoke-on-Trent by Staffordshire and Stoke-on-Trent Partnership NHS Trust)

3.5 Interdependence with other services/providers

The Provider shall work with the following organisations to deliver services (see Appendix 9 service pathway)

- Local General Practitioners (GPs) across Cannock Chase, Stafford & Surrounds
- Local NHS services including Podiatry, Adult Weight Management, Dietetics, Tissue Viability, Community Nurses, Secondary Care and other specialist services

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Other

- National Service Framework for Diabetes: Standards (2001)
- National Service Framework for Diabetes: Delivering Strategy (2002)
- Minding the Gap: The provision of psychological support and care for people with diabetes in the UK - A report from Diabetes UK
- Emotional and Psychological Support and Care in Diabetes: a report by Diabetes UK
- Think Glucose – NHS Institute for Innovation and Improvement
http://www.institute.nhs.uk/quality_and_value/think_glucose/welcome_to_the_website_for_thinkglucose.html

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

4.3 Applicable local standards

The Provider should ensure that the Service operates within budgetary constraints and with regard to the management of resources and priorities.

Staffing requirements

The staffing establishment will ensure service coverage by all disciplines 52 weeks a year.

The Provider shall ensure that policies and procedures are in place that ensures:

- All staff employed or engaged by the Provider are informed and aware of the standards of performance they are required to promote.
- Staff performance is routinely monitored and that any remedial action is taken where levels of performance are not in line with the agreed standards of performance.
- There are clear lines of responsibility and accountability for all members of staff.
- Conflicts of interest are resolved without impact on the service provision.

5. Applicable quality requirements and CQUIN goals

5.5 Applicable Quality Requirements (See Schedule 4A-C)

Diabetes is not included in the National Operational Requirements or the National Quality Requirements. For these elements of the pathways, quality will therefore be regulated through local quality requirements.

There is a NICE Quality Standard for Diabetes(QS6) which outlines clinical best practice. It provides specific, concise quality statements, measures and audience descriptors to provide patients and the public, health and social care professionals, commissioners and service providers with definitions of high-quality care.

<https://www.nice.org.uk/guidance/qs6>

Diabetes care is included in the Quality and Outcomes Framework (QOF)

<http://www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%202016/2015%20QOF%20guidance%20for%20stakeholders.pdf>

The Provider will fully participate in the National Diabetes Audit, where applicable.

Quality requirement	Indicator	Threshold	Method of Measurement
Increase in the uptake of patient education	% of patients referred that complete the Structured Education course % of patients referred that complete at least one session of the bite size course	End of Q1 45%, Q2 48% (to be reviewed at end of Q2), Q3 52%, Q4 55%, Q5 TBC for both Structured Education and bite size courses	Quarterly for both Structured Education and Bite Size Education
Proactive management of patients to reduce the frequency and severity of acute exacerbations	Urgent patients will receive access to the service within 2 days of referral (working days only) – when consideration of risk of patient of waiting up to 6 weeks	90%	Monthly reporting

Proactive management of patients to reduce the frequency and severity of acute exacerbations	Routine referrals will receive access to the service within 6 weeks of referral (working days only)	90%	Monthly reporting
Provide high quality Diabetes care, as defined by NICE Quality Standard (QS6), to all patients	Initial questionnaire: to establish the baseline for Diabetes patients Follow up questionnaire: post 6 months treatment to evidence impact of intervention	70% of patients to undertake the questionnaire	Quarterly Report
Provide high quality Diabetes care, as defined by NICE Quality Standard (QS6), to all patients	Patient reported outcomes (via survey to demonstrate an increase/improvement): % of patients with diabetes reporting an improvement in wellbeing and quality of life % of patients that are happy with the services they are able to access which enables them to self-care % of patients that are able to self-care and manage their own conditions	To demonstrate improvement in patient outcomes - 30% increase from initial questionnaire to follow up questionnaire	Quarterly Report
Training: Evidence from the Provider of the training support delivered to Primary Care	Annual Protected Learning Time sessions to GPs and Practice Nurses, delivered by the Provider in each individual CCG each year	100%	To be reported on at end of Q3
Mentoring: Provider upskilling identified Practice Nurses and GPs to deliver the minimum standards for Diabetes Care (Appendix 3 of the specification)	Offer GP practices mentoring support (in liaison with CCG primary care development managers, focusing particularly on those practices identified as benefiting from upskilling) and report on any issues/ obstacles raised	95%	Quarterly Report
Enhancing the local peer networks and support groups	The Provider to develop and facilitate a monthly peer support group for Diabetes % of patients/carers referred to local networks and support groups and self-care resources (e.g. online)	Peer support group to be established by the end of Q1 90%	Quarterly Report

5.6 Applicable CQUIN goals (See Schedule 4D)

There are no nationally applicable CQUINS for diabetes.

6. Location of Provider Premises

The Service should be provided in a variety of locations, within networks across localities, including within GP Practices and community settings e.g. clinics. Consideration should be given to reducing excessive travelling times, with clinics to be delivered across a number of individual practices.

All facilities should be comfortable, mindful of discretion and patient safety and are easily accessible. The hours of service must fit around the needs and requirements of the patients.

Locations should not be changed without prior discussion and agreement by Commissioners.

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 Beecroft 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.

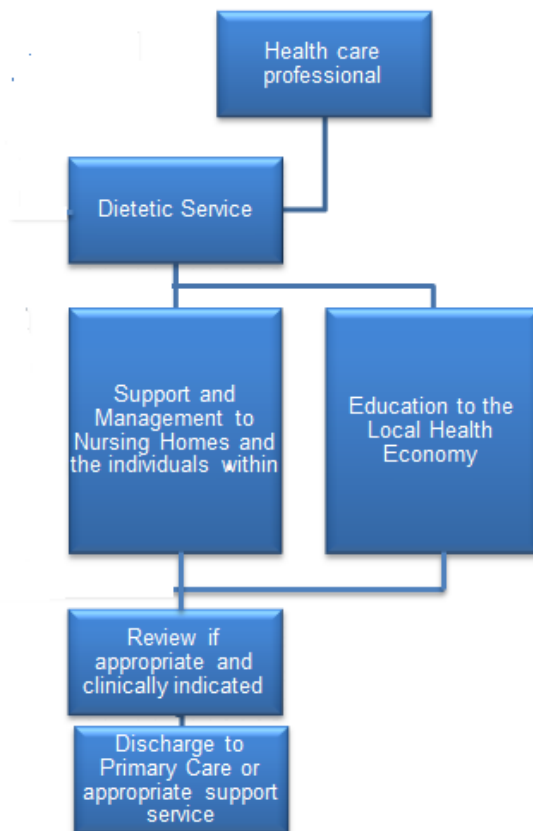
Providing Nursing Home Support The service will provide nutritional assessment and monitoring for all referred patients living in care with the addition of actively working with the care provider to empower them to take a 'Food First Approach' to malnutrition to drive down the cost and inappropriate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

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

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>

Service Specification No.	CS_24															
Service	Community MSK Service (IPOPS)															
Commissioner Lead																
Provider Lead	Adam McKeown															
Period	1 st April 2022 to 31 st March 2023															
Date of Review	By 31 st March 2023															
1. Population Needs																
National & Local context																
1.1.1	There are over 200 musculoskeletal conditions affecting millions of people, including all forms of arthritis, back pain and osteoporosis. The World Health Organisation (WHO) AND Bone and Joint Health strategies Project (2005 cited by DOH) identified that: - Up to 30% of all GP consultations are about musculoskeletal complaints - Musculoskeletal problems are cited by 60% of people on long term sickness 40% of the over 70's have Osteoarthritis (OA) of the knee - An estimated 8-10 million of the UK population have arthritis, including 1 million adults under the age of 45, upwards of 12,000 children and 70% of 70 year olds 80% of people report low back pain at some point in their life - It is estimated that trauma caused by road traffic accidents (RTA's) will be the third highest ranked cause of disability by 2020⁸															
1.1.2	The NHS Five Year Forward View aims to deliver better health, better patient care and greater efficiency within the NHS. To help support delivery of this vision, Sustainable Transformation Plans (STP) are being written across the health systems to show how providers and commissioners will evolve and become sustainable over the coming years.															
1.1.3	In 2014 Cannock and Stafford CCG commissioned an Integrated Musculoskeletal Clinical Assessment & Treatment Service which became the GPs first point of contact to triage all patients presenting with a Musculoskeletal condition. South East Staffordshire & Seisdon CCG also went through a programme of redesign in 2015 to adopt a similar model of care which aligned with the DOH MSK Framework (2006)															
1.1.4	Both services now manage over 70% of the patients referred to them and this service specification aims to pull together the two services to provide a clear pathway of care with greater efficiencies to align with the local STP plans for orthopedics.															
2. Outcomes																
2.1	<u>NHS Outcomes Framework Domains & Indicators</u> <table><tr><td>Domain 1</td><td>Preventing people from dying prematurely</td><td></td></tr><tr><td>Domain 2</td><td>Enhancing quality of life for people with long-term conditions</td><td>X</td></tr><tr><td>Domain 3</td><td>Helping people to recover from episodes of ill-health or following injury</td><td>X</td></tr><tr><td>Domain 4</td><td>Ensuring people have a positive experience of care</td><td>X</td></tr><tr><td>Domain 5</td><td>Treating and caring for people in safe environment and protecting them from avoidable harm</td><td>X</td></tr></table>	Domain 1	Preventing people from dying prematurely		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
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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 Please see schedule 4 Local Quality Requirements															

3. Scope

3.1 Aims and objectives of service

3.1.1 The provider shall provide a multi-disciplinary, single point of access; community based service which aims to provide timely assessment, diagnosis and treatment of MSK conditions and promotes self-management in order to maximize independence.

The overall aims and objectives of the service are:

- Provide a range of supportive care, advice and treatment for patients with musculoskeletal conditions;
- Facilitate improved health outcomes by reducing the need for surgical intervention where clinically appropriate, and to optimise self-care and self-management;
- Ensure improved patient reported outcomes by using evidence based outcome tools
- Support patients to gain improved physical, emotional and social well-being through reduction in pain/stiffness during periods of exacerbation/injury'
- To implement choice at the point of (onward) referral
- To include the specialist triage of musculoskeletal referrals to ensure patients are seen in the right place by the right person at the right time and actively manages inappropriate referrals through education and support.
- Reduce Service User's with back pain dependency on injection therapy by providing best practice long term management strategies and education to empower the Service User to undertake, and participate in, routine day to day activities.
- To prevent avoidable chronicity for acute Service Users and facilitate optimal quality of life in Service Users with long term un-resolving back pain.
- To use the information contained in the STarT Back Tool as a means to implement stratified care for Service Users with back pain

3.1.2 The Provider shall contribute towards the following outcomes:

- Reduced number of days lost to employment/loss of functional activity;
- Reduced social isolation;
- Reduced time spent off work;
- Reduction in time spent in acute settings;
- Improved musculoskeletal health;
- Reduction in secondary care orthopaedic referrals;

3.2 Service description

3.2.1 The core services shall include:

- Triage, assessment, diagnosis and treatment for Orthopaedic conditions – provided by a multidisciplinary team which includes consultant input appropriate to the condition
- Direct access to diagnostics (ensuring that they are requested appropriately – Royal College of Radiologists 2003) and undertaken prior to first appointment where clinically appropriate.
- Outpatient Procedures in line with the CCG's policy for Excluded and Restricted Procedures (ERP).
- Option to extend interventions as and when innovation and clinical developments are made, this would be agreed by all parties. Pain management services, including appropriate access to psychological support. Delivered directly within the MSK service, or has a seamless pathway into a separately managed service with the same Provider.
- MSK Podiatry (excluding surgery and community podiatry) already present in MICATS Service and further development to include in IPOPS further development
- Physiotherapy
- Orthotics – Bio mechanical assessment and low level advice & off the shelf products
- Chronic Back Pain Management classes.
- Self-Management and education interventions that follow best practice and national guidelines.

3.2.2 The Provider shall adopt and develop innovative ways of working and consider the following:

- Telephone assessment
- One stop clinics
- Alternative ways to face to face FU
- Support from the voluntary sector

3.2.3 The Provider shall ensure that each patient is provided with the following condition-specific information:

- Description of their condition and its implications;

- Self-Management training and support which empowers the patient to manage their condition and remain as independent as possible in their own home, for as long as possible, this includes the use of digital technology.
- Sources of Support;

- 3.2.4 Where there is a current pathway in place (South East Staffs), the Provider shall provide post-operative rehabilitation and physiotherapy in order to facilitate faster recovery for a range of surgical procedures undertaken in secondary care.
- 3.2.5 For patients with back pain symptoms, the Provider shall use the STarT Back screening tool to establish a Service Users risk status and the level of input that may be required. GPs will be encouraged to complete the STarT Back tool questionnaire to support the initial referral.
- 3.2.6 The Provider shall ensure that prescribing, administration and supply of medicines should be initiated for all treatment that is urgent or require immediate attention i.e. any treatment necessary within 7-10 working days. In all other circumstances, any non-urgent recommendations should be communicated back to the GP within 5 days by email or letter. The clinic letter shall be legible and shall state the patient management plan including any changes in medication including any that have stopped or initiated. Prescribing should follow local guidelines and formularies and ensure legal and clinical governance in safe storage, supply prescribing and administration of medicines.
- 3.2.7 If medicines are to be prescribed or administered the provider shall seek their own professional advice to ensure compliance to legislation on safe supply, storage and administration of medicines and make appropriate provision to use Patient Group Directions, pre-packs or prescribing within a clinical governance framework. The Provider shall prescribe in line with the South Staffordshire formulary.

3.3 Care Pathway

Accessing the Service

- 3.3.1 The Provider shall deliver appropriate triage of MSK referrals within 5 working days to ensure that patients are seen in the right place, by the right person at the right time and actively manages inappropriate referrals.
- 3.3.2 The Provider shall offer an initial appointment no more than 3 weeks and 6 days after the patient has opted into the service. Which may lead onto an assessment (face to face or telephone) diagnostics or treatment. Where patients have chosen to wait longer then this will need to be evidenced to the Commissioners.
- 3.3.3 The Provider shall ensure the choice, referral and booking conditions are in line with Service Condition 6 of the main contract.
- 3.3.4 The Provider shall arrange diagnostic tests for all Service Users who have not received the required diagnostics before entering the service where clinically appropriate.
- 3.3.5 Referrals will be rejected where the information contained in the referral is not enough to decide on the appropriateness, including exclusion of red flag symptoms or signs or those that do not meet the criteria for the MSK Service. Referrals will be returned to the source of referral, with reason for rejection, within one week of receipt.
- 3.3.6 Service Users shall be given a choice of appointment date and times. Service Users who do not attend (DNA) the service will not be offered a second appointment and the referral will be returned to the GP; however the Provider must provide assurance that the patient has received and accepted the original appointment. The provider shall not be paid for DNA's the SSoTP DNA Policy will be followed.
- 3.3.7 The Provider shall ensure that the service is available for patient consultations 52 weeks per year, with the exception of bank holidays. The Service shall be available a minimum of 5 days and between a range of hours offering extended hours per week between 8am-6.30pm and will also include extended hours, for example evenings and Saturday mornings.

Onward Referral

- 3.3.8 The Provider shall ensure that all Service Users who have received an intervention with the service and require a surgical opinion are referred within the referral to treatment RTT standards.
- 3.3.9 If surgery is likely to be required the Service User will undergo a basic pre-assessment, to determine fitness for surgery and be offered a choice of surgical provider. Prior to this the Provider shall adopt shared decision making principles to ensure the patient is fully aware of their options. Where applicable the Service User shall be directed to the Right Care decision aids: <http://sdm.rightcare.nhs.uk/pda/>

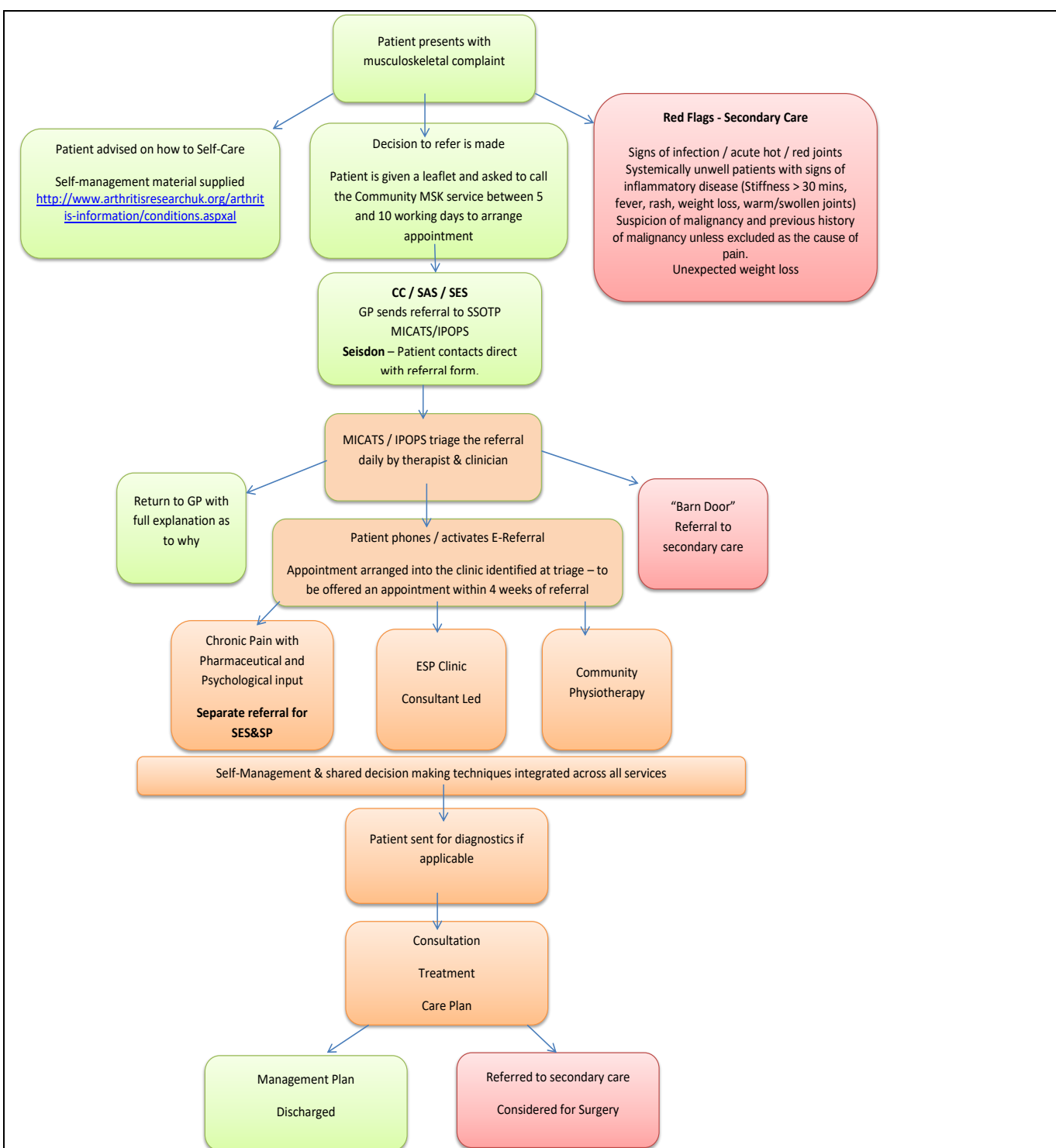
Post treatment complications

- 3.3.10 The management of complications such as wound infection following procedures undertaken by the Provider shall be the responsibility of the Provider. These Service Users will be seen as an emergency at the next available clinic appointment if clinically appropriate and should secondary care management be necessary the Provider should liaise with secondary care. Infection rates will be reported to the Commissioner.
- 3.3.11 The Provider shall have in place developed policies and appropriate equipment at the sites at which services are provided to be able to deal adequately with medical emergencies which might occur (e.g. anaphylaxis).

Discharge Requirements

Please refer to service condition 11

Patient Pathway



GP Links / Education

- 3.3.12 The provider shall provide clinical education to other health professionals within the CCG localities.
- 3.3.13 The Provider shall ensure that they offer advice and guidance to clinicians who are unsure of whether a patient requires a referral.

- 3.3.14 The Provider shall build relationships with local GP Practices and work towards having named physiotherapists working with a cluster of practices. The GP link Physiotherapists shall work as part of a multi-disciplinary team approach across their cluster of General Practices and be responsible for an active case load.
- 3.3.15 The Provider shall build relationships and clear pathways with secondary care consultants to ensure patients who require onward referral for surgical opinion are:
- Medically optimising the patient's condition prior to procedure;
 - Assessing the risk and fitness for surgery prior to referral
- 3.4 Population covered**
- 3.4.1 The Provider shall provide services to all Service Users registered with a General Practitioner in Cannock Chase Clinical Commissioning Group (CCG) Stafford and Surrounds CCG and South East Staffordshire & Sesidon CCG for whom the Commissioner is responsible for funding healthcare services.
- 3.4.2 For clarity referrals from Cannock Chase CCG & Stafford & Surrounds CCG shall be treated under the MICATS service and South East Staffordshire and Sesidon CCG patient shall be treated under the IPOPS service.

3.5 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

- 3.5.1 Any Musculoskeletal condition for but not limited to:
- Ligament injuries
 - Sprains and strains
 - Over-use injuries
 - Chronic Pain Management (for SES&SP patients a referral will go direct to the service)
 - Osteoarthritis
 - Acute & Chronic (three+ months duration) Back Pain & Neck Pain
 - Osteoarthritis
- 3.5.2 These conditions will be treated for the following areas:
- Upper limb
 - Lower Limb
 - Spinal
 - Foot & Ankle
 - Hand & Wrist

For the avoidance of doubt this service will accept patients 12 & above

Service Exclusions

- Any patient that is not registered with one of commissioners GP Practices.
- Patients who display red flag symptoms which include (but not exclusive) to be referred direct to secondary care:
 - Signs of infection /acute hot/ red joints
 - Systemically unwell patients with signs of inflammatory disease (stiffness > 30 mins, fever, rash, weight loss, warm/swollen joint)
 - Suspicion of malignancy and previous history of malignancy unless excluded as the cause of pain.
 - Unexpected weight loss
- Symptoms of cauda equina syndrome (saddle anaesthesia, bladder and/or bowel dysfunction)
- Community Podiatry / Podiatric Nail Surgery
- Specialist Orthotics
- Suspicion of fracture or dislocation
- Severe joint instability
- Haemarthrosis
- Re-referral for chronic conditions, without new symptoms reported.
- Stand alone acupuncture requests
- Vertigo
- Bells Palsy
- TMJ problems
- Chronic fatigue/Fibromyalgia
- Obstetric pain and SPD in IPOPS SES – usually referred to Specialist Obstetric Physio at Queens
- Post natal back pain within 3 months of birth or non-specific back pain of less than 2 weeks.
- Replacement collars and futura splints

- Respiratory
- Neurological
- Fallers/Mobility Assessments
- Inflammatory joint disease
- Patients who have experienced violent trauma, unless fracture has been excluded.
- Surgical Rehabilitation including private patients
- Patient who require a second surgical opinion
- Complex Feet will be seen in the MICATS service only

3.6 Interdependence with other services/providers

- 3.6.1 The Provider shall work in an integrated manor with the following NHS and Independent sector agencies: Acute & community care providers; Independent Diagnostic Providers; Social services and 3rd sector organisations, Patient groups, GPs, Keele University / Research Networks, Public Health, Mental Health providers, Equipment stores, Employers & Job Centre plus, Education providers, Patient Transport and other community services.
- 3.6.2 The service shall have seamless pathways into the other services provided under separate contract with the commissioners, eg the pain management service.

3.7 Research

- 3.7.1 The provider shall engage with research projects funded by NIHR (National Institute for Health Research), NHS or educational providers.
- 3.7.2 The provider shall promote research and innovation and the use of research evidence. The provider may also have to facilitate access for University Researchers. The provider shall comply with the Research Governance Framework for Health and Social Care

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE clinical guidance 96 "Neuropathic Pain – The pharmacological management of neuropathic pain in adults in non-specialist settings
- NICE clinical guidance 88, "Low back pain: Early management of persistent non-specific low back pain"
- The British Pain Society and the Royal College of General Practitioners (2004) "A practical guide to the provision of Chronic Pain Services for adults in Primary Care."
- Osteoarthritis: Care and management in adults, NICE guidelines [CG177] Published date: February 2014
- Osteoarthritis, NICE quality standard [QS87] Published date: June 2015

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

- British Pain Society (2007) "Recommended guidelines for Pain Management Programmes for adults."
- DH (2006) Musculoskeletal Service Framework: a joint responsibility – doing it differently
- DH (2008) High Quality Care for All – NHS Next Stage Review Final Report
- DH (2011) Safeguarding Adults

4.3 Applicable local standards

- STarT Back Screening Tool <http://www.keele.ac.uk/sbst/>
- Procedures of Low Clinical Value Policy relating to the MSK condition and pain management.
<http://sesandspccg.nhs.uk/news-and-information/publications/gp-information>

5. Applicable quality requirements and CQUIN goals

5.7 Applicable Quality Requirements (See Schedule 4A-C)

Schedule 4 Quality Requirements C Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
To ensure that patients can be offered an initial appointment in less than 4 weeks from the date of referral. Where patient chooses to wait longer the earliest available appointment must be logged and reported separately and will be subject to audit.	85%	Monthly performance dashboard.	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Community MSK Service
To ensure all patients are triaged, assessed and treated within the service and no more than 30% are referred to secondary care following triage.	70%	Monthly performance dashboard	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Community MSK Service
To ensure that those patients who do need to be referred to secondary care are done so in a timely manner once the decision to refer is made, and no later than 8 weeks from the date of referral.	8 weeks	Monthly performance dashboard	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Community MSK Service
To ensure that 90% of audit sample patient experiences are reported as positive and that they would recommend the service to family or friends.	90%	Monthly performance dashboard	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Community MSK Service
IPOPS service to demonstrate improvements in Patient Numerical Score and or Patient Specific functional scale Going forward the MSK HQ score will be used timescales to be agreed	85%	Monthly performance dashboard	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Community MSK Service
MICATs service to demonstrate patient outcomes using EQ-5D-5L Going forward the MSK HQ score will be used timescales to be agreed	85%	Monthly performance dashboard	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Community MSK Service
The Trust to carry out a 6 monthly audit on provider cancelled appointments/clinics with supporting detail	Audit	6 monthly audit	Issue of Contract Performance Notice and subsequent process in accordance with GC9	6 monthly	Community MSK Service

Schedule 6 – Contract Management, Reporting and Information Requirements - A Reporting Requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Monthly Data Sheet	Monthly	Excel spreadsheet – Data headings attached:	Submit to Coordinating Commissioner within 15 Operational Days of the	

		See appendix one for MSK Data Headings	end of the month to which it relate.	
Total number of patients referred into the service, split by E-referral, email and post.	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Total number of appointments, split to show the number of cancellations (by trust and by patient)	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Total number of patients referred onto secondary care split by trust and specialty (UHNM, RWT, Rowley, Burton, Walsall, Dudley) (T&O, Rheumatology, Pain Management, Spinal, Podiatric Surgery, orthotics, Occupational Therapy, other)	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Number of clinics offered out of hours	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Number of referrals into the service by category (ESP Podiatry, Pain Management, MSK, ESP Physiotherapy,	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Number of rejected referrals, by category (inappropriate for service, lack of information, referred elsewhere)	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Number of patients on the waiting list and the number of weeks waiting	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Number of patients sent for diagnostics by type (X-Ray, MRI, Ultrasound, Dexa, Bloods, CT, Nerve Conduction Studies) Report by exception any patient who waits more than 6 weeks for a diagnostic	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Number of patients seen by the service by condition (Shoulder, Hand/Wrist, Elbow, Knee, Spine, Hip, Foot/Ankle, Neck, other)	Monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	
Patient, Staff & Carer survey results A minimum of 100 patients a month to be surveyed across the services.	6 monthly	Monthly performance dashboard	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	

5.8 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

The provider shall operate out of a range of premises for easy access for the Localities

Service name	(NIMS) North Staffordshire and Stoke on Trent Integrated Musculoskeletal Service
Service specification number	CS_25
Population and/or geography to be served	Patients registered with GP practice within North Staffordshire and Stoke on Trent

Service aims and desired outcomes
Aims and objectives of service The provider shall provide a person centred multi-disciplinary, single point of access; musculoskeletal community based service which aims to provide timely assessment, diagnosis and treatment of MSK conditions and promotes self-management in order to maximize independence. The overall aims and objectives of the service are: • Provide a person centred service which provides timely assessment, evidence based management where appropriate and supported self-management • Facilitate improved health outcomes by reducing the need for surgical intervention where clinically appropriate, and to optimise self-care and self-management; • Ensure improved patient reported outcomes by using evidence based approaches that are captured on valid and reliable outcome tools • Through a Shared Decision making process, the service will support patients to gain improved physical, emotional and social well-being, where possible. • To implement choice at the point of (onward) referral • To include the specialist triage of musculoskeletal referrals, through a single point of access, to ensure patients are seen in the right place by the right person at the right time and actively manages inappropriate referrals through education and support. • Reduce Service User's with back pain dependency on injection therapy by providing best practice long term management strategies and education to empower the Service User to undertake, and participate in, routine day to day activities. • To prevent avoidable chronicity for acute Service Users and facilitate optimal quality of life in Service Users with long term un-resolving back pain. • To utilise the STarT Back approach as a means to implement stratified care for Service Users with back pain, in accordance with NICE Guidance The Provider shall contribute towards the following outcomes,: • Reduced number of days lost to employment/loss of functional activity; • Reduced social isolation; • Reduced time spent off work; • Reduction in time spent in acute settings; • Improved musculoskeletal health;

- Reduction in secondary care orthopaedic referrals;

Service description and location(s) from which it will be delivered

Service description

The core services shall include:

- Triage, person centred assessment, diagnosis and treatment for Musculoskeletal conditions— provided by a multidisciplinary team using a Shared Decision Making model as per NICE Guidance <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making>
- Provide access to diagnostics (ensuring that they are requested appropriately – Royal College of Radiologists 2003).
- Outpatient Procedures in line with the CCG's policy for Excluded and Restricted Procedures (ERP).
- Option to extend interventions as and when innovation and clinical developments are made, this would be agreed by all parties.
- Pain management services, including appropriate access to psychological support. Delivered directly within the MSK service, or has a seamless pathway into a separately managed service with the same Provider.
- MSK Podiatry
- Evidence Informed Community Physiotherapy
- Orthotics – Bio mechanical assessment and low level advice & off the shelf products
- A person centred approach that will be based on Shared Decision making, will promote supported Self-Management and education interventions that follow best practice and national guidelines.
- Patient self-referral
- A blended approach to the Consultations and management model i.e. virtual and face to face may be offered

The Provider shall adopt and develop innovative ways of working and consider the following:

- Ability of patient to referral
- Maximise Integrated Care
- Explore the prevention of MSK conditions in the health economy

The Provider shall adopt a Patient Centred approach and where agreed with the patient will provide the following A description of their condition and its implications;

- Supported self-Management support which empowers the patient to manage their condition and remain as independent as possible in their own home, for as long as possible, this includes the use of digital technology.
- Sources of Support
- All information will be communicated in way that the service user and carer can understand

For patients with back pain symptoms, the Provider shall use the STarT Back screening tool to establish a service Users risk status and the level of input that may be required. GPs will be encouraged to complete the STarT Back tool questionnaire to support the initial referral.

The Provider shall ensure that prescribing, administration and supply of medicines should be initiated for all treatment that is urgent or require immediate attention i.e. any treatment necessary within 7-10 working days. In all other circumstances, any non-urgent recommendations should be communicated back to the GP within 5 days by email or letter. The clinic letter shall be legible and shall state the patient management plan including any changes in medication including any that have stopped or

initiated. Prescribing should follow local guidelines and formularies and ensure legal and clinical governance in safe storage, supply prescribing and administration of medicines.

Care Pathway

Accessing the Service

The Provider shall deliver appropriate triage of MSK referrals, through a Single Pointt of Access within 5 working days to ensure that patients are seen in the right place, by the right person at the right time and actively manages inappropriate referrals.

The Provider shall offer an initial appointment no more than 3 weeks and 6 days after the patient has opted into the service. Which may lead onto an assessment (face to face or virtual diagnostics, treatment or self management. Where patients have chosen to wait longer then this will need to be evidenced to the Commissioners.

The Provider shall ensure the choice, referral and booking conditions are in line with Service Condition 6 of the main contract.

The Provider shall arrange diagnostic tests for all Service Users who have not received the required diagnostics before entering the service where clinically appropriate.

Referrals will be rejected where the information contained in the referral is not enough to decide on the appropriateness, including exclusion of red flag symptoms or signs or those that do not meet the criteria for the MSK Service. Referrals will be returned to the source of referral, with reason for rejection, within one week of receipt.

Service Users shall be given a choice of appointment date and times. Service Users who do not attend (DNA) the service will not be offered a second appointment and the referral will be returned to the referer; however, the Provider must provide assurance that the patient has received and accepted the original appointment. MPFT DNA Policy will be followed.

The Provider shall ensure that the service is available for service user consultations 52 weeks per year, with the exception of bank holidays. The Service shall be available a minimum of 5 days and between a range of hours offering extended hours per week between 8am-6.30pm and will also include extended hours..

Onward Referral

The Provider shall ensure that all Service Users who have received an intervention with the service and require a surgical opinion are referred.

If surgery is likely to be required the Service User will undergo a basic pre-assessment, to determine fitness for surgery and be offered a choice of surgical provider. Prior to this the Provider shall adopt shared decision-making principles to ensure the patient is fully aware of their options. Where applicable the Service User shall be directed to the Right Care decision ids: <http://sdm.rightcare.nhs.uk/pda/>

Post treatment complications

The management of complications such as wound infection procedures undertaken by the Provider shall be the responsibility of the Provider. These Service Users will be seen as an emergency at the next available clinic appointment if clinically appropriate and should secondary care management be necessary the Provider should liaise with secondary infection rates will be reported to the Commissioner.

The Provider shall have in place developed policies and appropriate equipment at the sites at which services are provided to be able to deal adequately with medical emergencies which might occur (e.g. anaphylaxis).

GP Links / Education

The provider shall provide clinical education to other health professionals within the CCG localities, upon request and costs will be covered by GPS/PCNs.

The Provider shall ensure that they offer advice and guidance to clinicians who are unsure of whether a patient requires a referral.

The Provider shall build relationships with local GP Practices and work towards having named physiotherapists working with a cluster of practices. The GP link Physiotherapists shall work as part of a multi-disciplinary team approach across their cluster of General Practices and be responsible for an active case load.

The Provider shall build relationships and clear pathways with secondary care consultants to ensure patients who require onward referral for surgical opinion are:

- Medically optimising the patient's condition prior to procedure;
- Assessing the risk and fitness for surgery prior to referral

Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

Any Musculoskeletal condition for but not limited to:

- Ligament injuries
- Sprains and strains
- Over-use injuries
- Osteoarthritis
- Acute & Chronic (three+ months duration) Back Pain & Neck Pain
- Osteoarthritis

These conditions will be treated for the following areas:

- Upper limb
- Lower Limb
- Spinal
- Foot & Ankle
- Hand & Wrist

Service Exclusions

- Any patient that is not registered with one of commissioners GP Practices.
- Patients who display red flag symptoms which include (but not exclusive) to be referred direct to secondary care:
 - Signs of infection /acute hot/ red joints
 - Systemically unwell patients with signs of inflammatory disease (stiffness > 30 mins, fever, rash, weight loss, warm/swollen joint)
 - Suspicion of malignancy and previous history of malignancy unless excluded as the cause of pain.
 - Unexpected weight loss
- Symptoms of cauda equina syndrome (saddle anaesthesia, bladder and/or bowel dysfunction)
- Community Podiatry / Podiatric Nail Surgery
- Specialist Orthotics
- Suspicion of fracture or dislocation
- Severe joint instability
- Haemarthrosis
- Re-referral for chronic conditions, without new symptoms reported.
- Stand alone acupuncture requests
- Vertigo
- Bells Palsy
- TMJ problems
- Chronic fatigue/Fibromyalgia
- Obstetric pain and SPD in IPOPS SES – usually referred to Specialist Obstetric Physio at Queens
- Post natal back pain within 3 months of birth or non-specific back pain of less than 2 weeks.
- Replacement collars and futura splints
- Respiratory
- Neurological
- Fallers/Mobility Assessments
- Established diagnosis of Inflammatory joint disease
- Patients who have experienced violent trauma, unless fracture has been excluded.
- Surgical Rehabilitation
- Patient who require a second surgical opinion

Interdependence with other services/providers

The Provider shall work in an integrated manor with the following NHS and Independent sector agencies: Acute & community care providers; Independent Diagnostic Providers; Social services and 3rd sector organisations, Patient groups, GPs, Keele University / Research Networks, Public Health, Mental Health providers, Equipment stores, Employers & Job Centre plus, Education providers, Patient Transport and other community services.

The service shall have seamless pathways into the other services provided under separate contract with the commissioners, e.g. the pain management service.

Service Specification No.	CS_26		
Service	Children's Continence Assessment Service (4-5 year olds)		
Commissioner Lead	Simon Runnett		
Provider Lead	Kate Cox		
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			
1.1.1 Continence, for the purpose of this specification, is the ability to voluntarily control emptying the bladder effectively in a socially acceptable and hygienic way.			
1.1.2 The National Institute for Health and Care Excellence (NICE) estimates that bladder and bowel dysfunction affects about 900,000 children and young people out of a population of 8,500,000 in the UK (NICE Paediatric Continence Commissioning Guide, 2010: 21). Of the latter, approximately 800,000 have a physical or learning difficulty (Austin et al, 2014).			
1.1.3 There is evidence that children with physical disabilities and learning difficulties have a higher incidence of continence problems, either due to an associated disorder of the bladder/bowel, or to their physical or intellectual impairment (Rasquin et al, 2006, Liu et al, 2000, Lee et al, 2000, Gur et al, 2004).			
1.1.4 Continence problems are believed to be caused by biological, developmental, genetic and environmental factors. Structural or anatomic causes are rare. They occur at a formative time for children - and influence their health, their wellbeing, and their emotional development. There is evidence that they are associated with emotional and behavioural problems including a strong association with bullying, both as recipients and perpetrators (NICE Clinical Guideline CG 99, 2010: 5; CG 111, 2010: 4).			
1.1.5 They can also reduce self-esteem at a crucial time for a child or young person's emotional development and risk their exclusion from normal social interaction, such as overnight school trips or sleepovers (NICE Clinical Guideline CG 99, 2010: 4; CG 111, 2010: 4).			
1.1.6 Whilst most parents are positively involved and concerned, a significant minority (estimated to be about 30%), respond by punishing their children for wetting accidents. This can result in a 'vicious cycle' of increased stress, more accidents, potentially harsher chastisement and the risk of child abuse (Chiozza et al, 1998)			
1.1.7 There is evidence that once the wetting and soiling is solved, the psychological problems are often resolved (Hellstrom et al, 1995).			
1.1.8 Continence problems are treatable, but may take months or even years to resolve, so it is important that they are diagnosed and managed early. This is particularly important for children and young people with learning and physical disabilities, who have a higher risk of underlying pathology.			
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		✓
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	✓
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 Children's Continence Assessment Service (4-5 year olds) across South Staffordshire should work in a collaborative way to assess the needs of the children with continence issues.

2.2.2 In order to assess the needs of these children, Health Visiting Teams are expected to:

- Provide an equitable service to the population of children that the service covers.
- Allow children to be assessed safely in the most appropriate location, including closer to home
- Provide early intervention for continence conditions
- Improve and maintain patient & parent/carer satisfaction
- Empower parents to care for their child at home
- Support and encourage children to self-care
- Promote the Early Help agenda
- Promote the priorities within the Staffordshire Children, Young People and Families' Strategy.
- Promote the Special Educational Needs and Disabilities reforms
- Work with other Health Visiting teams to share learning, improve services and reduce variation

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years.

Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support Can be accessed through The Designated Clinical Officer representing the CCGs.

Safeguarding

The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

As appropriate adult safeguarding procedures should be adhered to in all cases.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:
https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3. Scope

3.1 Aims and objectives of service

- 3.1.1 The service shall deliver a coordinated and evidence based approach to support children with complex continence needs. This will include children with special needs.
- 3.1.2 This includes the co-ordination and provision of continence products to support the child's continence needs following an appropriate assessment.

3.2 Referral Criteria and Pathway

- 3.2.1 Referrals can be made for a continence assessment for children registered to the universal Health Visiting service. The need for this assessment is usually indicated to the service by the parent or carer – this may be done within a contact session with a member of the Health Visiting team or may be through the parent/carer contacting the service directly to request an assessment. Assessment is carried out by a Band 6 Health Visitor using the RCN Readiness for Toilet Training assessment. The assessment will indicate whether the child's continence can be managed through advice or whether products are required. If products are required the Health Visitor will arrange samples and order the most appropriate products to meet the assessed needs of the child.

3.3 Service description/care pathway

- 3.3.1 Response time is variable and is identified during a Health Visiting contact.
- 3.3.2 The Health Visiting service operates from Monday – Friday 9am-5pm excluding Bank Holidays.
- 3.3.3 The service is available 52 weeks per year

3.4 Population covered

- 3.4.1 The Service will be delivered by the current Health Visiting Service across South Staffordshire (NHS Cannock Chase CCG, NHS East Staffordshire CCG, NHS South East Staffordshire and Seisdon Peninsula CCG, NHS Stafford and Surrounds CCG).
- 3.4.2 The continence assessment takes approximately 2 hours to complete by a registered Health Visitor. This is due to the nature of the cohort of individuals who are in receipt of this assessment – children 4/5 year olds who have special needs. The demand for these assessments will need to be kept under review and the capacity to meet this demand will need to be monitored as it is likely to increase over time.
- 3.4.3 There will need to be a further review of this specification prior to April 2018 as part of the tendering of a 0-19 Children and Young People Health and Wellbeing Programme by Staffordshire County Council.

3.5 Any acceptance and exclusion criteria and thresholds

- 3.5.1 The inclusion criteria is for children from 4-5 years of age who are receiving support from the Health Visiting service and registered with a GP from the following CCG areas; NHS Cannock Chase CCG, NHS East Staffordshire CCG, NHS South East Staffordshire and Seisdon Peninsula CCG, NHS Stafford and Surrounds CCG.

3.5.2 Exclusion – Any child over the age of 5 years old.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.1.1 The Children's Continence Assessment Service (4-5 year olds) and advice provided should comply with the following key legislation and guidance:

- Relevant NICE guidelines
- Relevant NPSA and MHRA safety guidance / alerts
- Association for Children with Life-Threatening or Terminal Conditions and their families, ACT (2004)
- Healthy lives, brighter futures – The Strategy for children and young people's health, DH / DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services DH (2006)
- NSF for Children, Young People and Maternity Services., DH (2004)
- Disabled Children and Young People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- DH (2003) Getting it right: National Service Framework for Children. Standards for Hospital Services.
- Working Together to Safeguard Children (2013)
- Children's Act (2004)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)

4.1.2 The above is not an exhaustive list of legislation & guidance and the provider would be expected to keep up to date with all relevant legislation, guidance and NICE guidance.

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

4.2.1 All health organisations must demonstrate how they have listened to the voice of children and young people and how this will be used to improve their health outcomes.
Children and Young People's Health Outcomes Forum (2012)

4.2.2 The Children's Continence Service (4-5 year olds) and advice provided should comply with The Code
(NMC, 2015)

4.3 Applicable local standards

4.3.1 The Children's Continence Service (4-5 year olds) will meet the priorities and outcomes of the Staffordshire Children, Young people and families Strategy 2016-2026

- Starting well
- Growing well
- Living Well

and

- Happy and healthy
- Safe and belongs
- Achieves and contributes

1.3.2 The Children's Continence Service (4-5 year olds) will be expected to comply with all Trust procedures, policies and practices.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

Schedule 6 – Contract Management, Reporting and Information Requirements - A Reporting Requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Number of referrals received	Monthly	Excel spreadsheet; split, by CCG,	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Number of continence assessments undertaken	Monthly	Excel spreadsheet; split, by CCG,	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Score of assessment	Monthly	Excel spreadsheet; split, by CCG,	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Continence products ordered	Monthly	Excel spreadsheet; split, by CCG,	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

Continence assessments are all carried out in the child's home.

7. Individual Service User Placement

Service Specification No.	CS_27	
Service	Chronic Pain Management – East Staffordshire	
Commissioner Lead	Emily Davies	
Provider Lead	Adam McKeown	
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		
7.8 million people live with chronic pain, £584 million is spent on prescriptions for pain, 1.6 million adults per year suffer with chronic back pain, 25% of people with chronic pain lose their jobs and 16% feel their chronic pain is so bad that they sometimes want to die (Donaldson, 2009). The principal aims of the chronic pain service are to enable people with chronic pain to achieve as normal a life as possible by reducing physical disability and emotional distress, and improving the individual's ability to self-manage pain-associated disability and reduce reliance on healthcare resources. Since 2005, the Department of Health approach for the management of long-term health conditions changed, increasing the emphasis on self-management skills and resources (for instance, the 2005 National Service Framework for long-term medical conditions. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/fs/; Clinical Standards Advisory Group, 2000; Dr Foster, 2003)¹.		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
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	✓
3. Scope		
3.1 Aims and objectives of service		
The Provider shall: • The Provider shall ensure appropriate triage of chronic pain referrals to ensure patients are seen in the right place, by the right person and actively manages inappropriate referrals, • Provide an effective service for the management of chronic pain sufferers, • Facilitate improved health outcomes by enhancing patient's ability to self-Manage and maximise functional ability, • Reduce the need for surgical intervention amongst chronic pain sufferers, • Ensure improved patient reported outcomes, • Reduce need for patients to be seen repeatedly by a specialist chronic pain service. The Provider shall contribute towards the following outcomes: • Reduced number of days lost to employment/loss of functional activity; • Reduced social isolation; • Reduction in time spent in acute settings;		

¹ The British Pain Society, Guidelines for Pain Management Programmes for adults, November 2013

- Reduce patient reliance on surgical or repetitive non-surgical interventions, especially those provided in the acute care setting, by providing a service that draws on the expertise of medical, physiotherapy, pharmacy and psychology specialties;
- Provide care closer to home and in the most appropriate community setting for the type of treatment being provided to the patient;
- Reduction in secondary care chronic pain intervention.

3.2 Service description

The service shall provide assessment and treatment for chronic pain and shall comprise of:

- Pain Management Programme, in accordance with the "Guidelines for Pain Management Programme for adults" British Pain Society, November 2013
- Physiotherapy
- Psychological Support
- Pharmacological Management
- Specialist in Pain Management
- Interventional
- Diagnostic investigations

The Provider shall ensure that each patient is provided with the following condition-specific information:

- Description of their condition and its implications;
- Self-Management advice and support
- Sources of Support
- Interventional Procedures

The Provider shall agree suitable reviews with the Patient to include the following:-:

- Review of agreed goals and Personalised Care Plan/Personalised Management Plan
- Patient experience
- Effectiveness of interventions
- Patient compliance with plan
- Reinforce self-management to empower and manage the condition with the use of digital technology or appropriate means
- Onward referral as necessary

3.3 Minor or Intermediate Procedures

The Provider shall undertake minor procedures which have been agreed with the East Staffordshire Clinical Commissioning Group including (but not limited to).

Out Patient based Nerve blocks, Joint and soft tissues injections and intermediate procedures such as Spinal injections etc. which are provided in controlled Theatre Environment

This will be in line the commissioners Procedures of Low Clinical Value policy

3.4 Medicines Management

The provider shall prescribe in line with any approved patient pathways inclusive of those published on Map of Medicine.

All prescribing must be in line with South Staffordshire Joint formulary as detailed within the hyperlink:

<http://www.southstaffordshirejointformulary.nhs.uk/> .

All non-formulary prescribing/ recommendations will remain with the provider and all costs will be recharged back to the provider.

If the provider would like to apply for a drug to be considered for addition to the formulary, the following document shall be used:

<http://www.southstaffordshirejointformulary.nhs.uk/docs/misc/FormularyApplicationForm.pdf>

Prescribing should be for products licensed within that indication or those contained within national guidelines (NICE) recognising certain products will be unlicensed for these indications, however are established therapy. However all products prescribed or recommended must be on the South Staffordshire Joint Formulary.

Where a formulary application is made for inclusion on the above formulary, and the South Staffordshire Area Prescribing Group identify a need for supporting essential shared care agreement (ESCA) or rationale for initiation, continuation and discontinuation (RiCad) documentation, it is the responsibility of the service to provide these.

All patients shall be stabilised on pharmacological treatment before discharge to the GP.

GPs shall be provided with clear instructions on dosing and any necessary titration where suitable and treatment goals for the short, medium and long term.

All prescribing shall be using non-proprietary or pharmacological i.e. 'generic' nomenclature; unless the proposed therapy has complex name.

The Provider shall ensure that prescribing, administration and supply of medicines are provided for all treatment that requires a rapid prescription request form initiation. The Provider shall communicate to patients that these will be processed within normal prescription volume. Non-urgent recommendations are communicated back to the GP.

3.3 Care Pathway

3.3.1 Accessing the service

The Provider shall accept referrals via secure email, Choose and Book or letter. All referrals shall be assessed by the Pain Management service for appropriateness and will be referred onto secondary care as appropriate. The Provider shall ensure that appointments are prioritised to those with greatest clinical urgency, based on the information provided in the referral letter.

The Provider shall arrange diagnostic tests for those Service Users where Clinically appropriate

Referrals will be rejected where the information contained in the referral is not enough to decide on the appropriateness, including exclusion of red flag symptoms or signs or those that do not meet the criteria for the Service. Referrals will be returned to the source of referral, with reason for rejection, within one week of receipt.

Service Users shall be given a choice of appointment date and times. Service Users who do not attend (DNA) the service will not be offered a second appointment and the referral will be returned to the GP; however the Provider must provide assurance that the patient has received and accepted the original appointment.

The Provider shall ensure that the service is available for patient consultations 42 weeks per year, with the exception of bank holidays. The Service shall be available 5 days per week between 8am-5.00pm.

The Provider shall provide Service Users with relevant information informing them of the services they should access if there is a complication outside of the normal service hours. The Provider shall ensure that there are arrangements in place to deliver the appropriate services for sensory impaired patients and those who do not speak English.

The Provider shall consider and understand the BME communities within the Clinical Commissioning Groups and ensure that the Service is accessible to all communities.

The service is located at:-

Based at Edwin House, running East Staffs clinics at:-

Injections at the Treatment Centre, Queens Hospital Burton

And clinics from-

Hill Street Health Centre

Stapenhill

Burton-on-Trent

Tel: **01283 507131 Patient Contact Line**

Fax: **01782 532349**

Secure nhs email address for referrals: **SSPCT.chronicpain@nhs.net**

Service is provided 42 weeks 9.00-4pm Mon-Friday excluding Bank Holidays

3.3.2 Onward referral

The Provider shall ensure that all Service Users who have received an intervention with the service and require further surgical or specialist opinion are referred to surgical providers within 8 weeks from receipt of referral and within two working days of the Providers decision to refer onwards. Choice principles will be applied when referring to secondary care.

When Service Users are referred onward, by the Chronic Pain Management service, the reason for the referral will be contained in the referral letter e.g. for surgery, a surgical opinion, or because of serious pathology. For any Service User which the Provider needs to refer, a full statement (the equivalent of a discharge letter to the GP) should be provided and made available to the receiving hospital or service within five working days. The Provider shall expedite this so as not to

compromise achievement of the 18 week referral to treatment targets. The Provider shall refer to any pre-referral surgical guidelines that the Commissioner and Secondary Care providers have in place before a referral for surgery is made.

The Provider shall be able to demonstrate the delivery of patient choice and ensure that all Service Users requiring onward referral are offered choice as per DH guidelines <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>.

3.3.3 Post treatment complications

The Provider shall have in place developed policies and appropriate equipment at the sites at which services are provided to be able to deal adequately with medical emergencies which might occur (e.g. anaphylaxis).

3.3.4 Discharge Requirements

The Provider shall be responsible for ensuring that the referring GP is sent a comprehensive typed summary letter outlining the diagnosis, investigations, treatment plan and patient advice following each patient consultation.

The Provider shall send the Service User a copy of the discharge letter and treatment plan in accordance with the Contract General Conditions.

At a clinically appropriate time following discharge the Provider shall contact each Service User to arrange the completion of Clinically appropriate outcome measure

3.4 Development of a patient centred service

The Provider shall ensure that Service Users, family and their Carers are given an explanation of their condition and advice about all management options including both non-surgical and surgical (if appropriate) in a manner that is easily understood.

The Provider shall work with Service Users, family and Carers in ways that foster partnerships. Providers shall develop processes such as comments and suggestion boxes, patient and carer participation groups, experience surveys, local complaints processes and annual reviews of the service.

The Provider shall work with Service Users, family and Carers in ways that support self-care and self- management and the supply of informative educational leaflets in the self-management of their condition.

The provider shall ensure that service provision is adapted to meet the needs of vulnerable people, people with learning and physical difficulties and mental health needs. The Provider shall comply with the national standards for ethnic coding.

3.5 Any acceptance and exclusion criteria and thresholds

3.5.1 Acceptance criteria

- The Provider shall accept all patients presenting chronic pain conditions (mechanical and other non-mechanical Chronic Pain conditions) with the exceptions detailed below. Referrals will be accepted from a GP, Physiotherapist, Occupational Therapist, Podiatrist or Consultant and any Health Care Professionals
- Patient's social and psychological wellbeing affected due to distress caused by chronic pain.
- Patients participation in daily activities is severely limited.
- Patients have had all possible investigations and not suitable for surgery.

3.5.2 Exclusion criteria

The Provider shall not accept referrals where it is apparent that the patient:

- Needs palliative pain relief, or is suffering from a rapidly deteriorating disease or condition.
- Has a history of a cancer potentially related to the pain
- Displays symptoms of a spinal tumour.
- Is suffering from the acute phase of a violent trauma
- Uncontrolled psychosis and moderate to severe cognitive impairment
- Any patient that is not registered with a East Staffordshire CCG GP
- Any patient assessed as a 'Red Flag
- Stand alone acupuncture requests
- Post natal back pain within 3 months of birth
- Paediatrics under the age of 16 years

3.3 Population covered

3.3.1

The Provider shall provide the Services to all patients with chronic pain conditions who are registered with an East Staffordshire CCG GP Practice for whom the Commissioner is responsible for funding healthcare services. Consideration will be given to homeless patients that are not registered.

3.5

Interdependence with other services/providers

3.5.1

The provider shall ensure that they build relationships with the following services/providers:

- Community Service Providers
- Integrated Physiotherapy Orthopaedic and Pain Service IPOPS Pharmacists (encouraging patients to ask their pharmacist for advice)
- District Councils to look at opportunities to develop strategies which encourage individuals to take up physical activity
- Voluntary Sector
- Urgent Care Centres/ Minor Injuries Units
- County Councils
- Secondary Care Providers

4.

Applicable Service Standards

4.1

Applicable national standards (eg NICE)

- British Pain Society (November 2013) "Recommended guidelines for Pain Management Programmes for adults"
- DH (2008) High quality Care for All – NHS Next Stage Review Final Report
- DH (2011) Safe Guarding Adults
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882
- National audit Office (2009) Services for people with rheumatoid arthritis

4.2

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

- NICE (2009) Rheumatoid arthritis: The management of rheumatoid arthritis in adults
- NICE clinical guidance 96 "Neuropathic pain – The pharmacological management of neuropathic pain in adults in non-specialist settings"
- NICE clinical guidance 88. "Low back pain: Early management of persistent non-specific low back pain"
- The British Pain Society and the Royal College of General Practitioners (2004) "A practical guide to the provision of Chronic Pain Services for adults in Primary Care"
- The National Pain Audit; <http://www.nationalpainaudit.org/index.html>
- The Royal College of Anaesthetists and the Pain Society (2003) "Pain Management Services – Good Practice"
- The Royal college of Physicians of London (2009) Rheumatoid Arthritis: National Clinical Guidelines for management and treatment of adults
- British Pain Society, Core Standards for Pain Management Services in the UK , October 2015

4.3

Applicable local standards

- <http://www.staffordshire.gov.uk/health/care/reportingabuse/vulnerableadultabuse.aspx>
- <http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/legalpolicy/mental-capacity/mac-cp.pdf>
- DH - Department of Children schools and Families (2010) Working Together to Safeguard Children

5.

Applicable quality requirements and CQUIN goals

5.1

Applicable quality requirements (See Schedule 4 Parts A-C)

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
% of patients report reduction in level of distress <i>Quantifiable improvements in patients' perception reduction in level of distress</i>	Threshold- 75% (of a sample size which must =>50% of referral activity	Quarterly report of % achieving improvement Brief Pain Inventory Tool	General Condition 9 Contract Management	Quarterly	Community Based Chronic Pain Management Service

% of patients reporting positive change in pain self-efficacy <i>Evidence of patients taking effective self control of their condition individually</i> <i>Local Outcome: Provide care in appropriate community setting for type of treatment being provided</i>	Threshold-75% (of a sample size which must =>50% of referral activity)	Quarterly report Brief Pain Inventory Tool	General Condition 9 Contract Management	Quarterly	Community Based Chronic Pain Management Service
% of service users with a reported improvement in their condition from the initial assessment to discharge from the service <i>Patients having a positive outcome in their physical, psychological and/or social needs</i> <i>Local Outcome: Reduced social isolation – linked in with positive outcomes</i>	75% (of a sample size which must =>50% of referral activity)	Quarterly Report Brief Pain Inventory Tool	General Condition 9 Contract Management	Quarterly	Community Based Chronic Pain Management Service
% of patients report an increase in functional gain- <i>An increase in an individual's self-reported levels of functional gain</i> <i>Local Outcome: Reduced LOSS of functional activity</i>	Threshold-75% (of a sample size which must =>50% of referral activity)	Quarterly Report Using an accredited tool to report reduction in self-reported levels of functional gain at point of discharge. Brief Pain Inventory Tool	General Condition 9 Contract Management	Quarterly	Community Based Chronic Pain Management Service
% of patients to be asked about an increase in an individual's self-reported levels of functional gain- Local Outcome: Reduced loss of functional activity <i>Patients have a positive experience of care</i>	Threshold to be based on SSOTP standard	Quarterly Report Tool - Friends and Family Test	General Condition 9 Contract Management	Quarterly	Community Based Chronic Pain Management Service

5.2 Applicable CQUIN goals (See Schedule 4 Part D)

Not applicable

6. Location of Provider Premises

The Provider's Premises are located at:

Based at Edwin House, running East Staffs clinics at:-
Injections at the Treatment Centre, Queens Hospital Burton

And clinics from-

Hill Street Health Centre

Stapenhill

Burton-on-Trent

Tel: **01283 507131 Patient Contact Line**

Fax: **01782 532349**

Secure NHS email address for referrals: **SSPCT.chronicpain@nhs.net**

Service is provided 42 weeks 9.00-4pm Mon-Friday excluding Bank Holidays

Service Specification No.	CS_28
Service	Specialist Weight Assessment and Management Service (SWAMS) for Severe and Complex Morbid Obesity)
Commissioner Lead	Emily Davies
Provider Lead	Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.1 National Context, reads as “The prevalence of obesity in England is one of the highest in the European Union.

Data from the Active People Survey suggests that around seven in ten adults have excess weight and three in ten are obese in East Staffordshire. Both rates are higher than the England average. This is coupled with poor diet and low physical activity levels across the CCG.

Research shows that 70% of patients undergoing Tier 3 service programme lose 10 kg of weight but only 20% maintain this weight loss after 5 years. The research assumes that patients maintaining the weight loss for 5 years will maintain the 10 kg weight loss for life. This is based on patients being discharged without any type of follow-up service.

Specialist Services should provide the link between Tier 1 and 2 environmental and population-wide services / lifestyle interventions, and Tier 4 Multidisciplinary Specialist Bariatric Surgical Services

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	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	x

2.2 Local defined outcomes /service specification anticipated outcomes measures

- % of patients who have maintained or lost weight in the first 12 weeks on the programme
- % of patients who have reduction in body weight by 5-10% or more in 6-12 months
- % of patients who increase distance walked on a 6 minute step test after 10 weeks or for less able patients improvement on sit to stand test (over 30 second period) after week 10. This outcome only relates to patients who are accessing the physical activity element of the programme and comes after 10 weeks engagement in said element of service.
- % patients who Increase activity on a weekly basis after 12 weeks
- % patients with health and wellbeing improvement

3. Scope

3.1 Aims and objectives of service

- To achieve realistic patient goals around weight and lifestyle for patients with complex obesity
- To increase number of patients who make long-term lifestyle changes to manage their weight, improve their health status and their quality of life.
- Manage access to bariatric surgery by providing a screening process for those who are eligible

3.2 Service Specification anticipated outcomes measures- please see above at 2.23.3 Service Description

The service provider will be expected to work with partner agencies to ensure coordinated service delivery across the full range of need and to signpost to other healthy living services or activities available locally.

The service will treat obesity and morbid obesity in a Specialised service to move towards a healthy BMI.

3.3 Inclusion Criteria

Adults who have attempted at least a combination of wellbeing services provided by Public Health (or other weight loss initiatives such as Weight Watchers, Slimming World etc.) for at least 6 months:

- BMI ≥ 50 kg/m² who may not have tried weight loss services but where the GP feels that the individual will benefit from Tier 3 input sooner
- BMI ≥ 40 kg/m² and failed attempts to lose weight
- BMI ≥ 35 kg/m² with complex needs including co-morbidities
- BMI ≥ 35 kg/m² with the recent onset of diabetes by GP discretion

There is a tolerance of unit BMI 2.5 kg/m² due to increased health risk at lower BMI on BME groups eg those with black African or Caribbean and South Asian heritage. High blood pressure alone is not a sufficient additional factor to warrant complexity and, therefore, referral to the service outlined in this specification.

3.5 Exclusion criteria

- Patients not registered with an East Staffordshire CCG GP practice
- Patients under the age of 18
- Patients who have a BMI ≤ 35 kg/m² or 27.5 for BME groups
- Pregnant women
- Those diagnosed with active substance abuse issues, including alcoholism. Patients should be stable for at least one year before being considered for referral.

3.6 Discharge

Patients should not routinely stay within the service beyond a year and certainly no longer than 18 months. All patients still in the service at 12 months will be assessed by appropriately trained personnel and remain in the service only if it is clinically necessary.

Patients requiring Bariatric Surgery may need further input whilst awaiting surgery. Patients who are failing to achieve their goals should be reassessed along the pathway and more intensive/frequent support offered if appropriate. Those who experience continued difficulty should be: -

- Considered for referral to the Tier 4 service (surgery), if they meet the criteria. Referrals to Bariatric Surgery will not be made unless the patient has completed 12 months in the service described in this specification.
- Discharged back to their GP if lack of motivation is the main barrier to weight loss, or if there are other medical reasons which mean they are not ready or able to engage.
- Signposted to other wellbeing services including other weight management programmes such as Weight Watchers/Slimming World.

3.7 Interdependence with other services/providers

The service provider will have interdependencies with Acute Trust Bariatric Services and signposted services.

4. Applicable Service Standards

4.1 Applicable standards (eg NICE)

- Managing overweight and obesity in adults – lifestyle weight management services (NICE clinical guideline G43, May 2014)
- NICE Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (NICE clinical guideline 189, November 2014)

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

- Provide a quarterly report on complaints received and action taken by the Provider on resolution.
- Provide a quarterly report on patient experience and action taken by the Provider to improve the patient experience.
- Provide a quarterly report on all incidents and serious incidents along with a report on action taken to prevent a reoccurrence and methods of sharing any learning across the service.
- Provide a quarterly training and workforce report.
- Exception report to be provided quarterly for any patient going over 12 months in the applicable three month period – these patients will have a review and the decision justified clinically.

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Local Reporting Requirements				
Provide a quarterly report on complaints received and action taken by the Provider on resolution	Quarterly	For local agreement	To commissioners on 15 th working day	Adult Weight Management Service
Provide a quarterly report on patient experience and action taken by the Provider to improve the patient experience	Quarterly	For local agreement	To commissioners on 15 th working day	Adult Weight Management Service
Provide a quarterly report on all incidents and serious incidents along with a report on action taken to prevent a reoccurrence and methods of sharing any learning across the service.	Quarterly	For local agreement	To commissioners on 15 th working day	Adult Weight Management Service
Provide a quarterly training and workforce report	Quarterly	For local agreement	To commissioners on 15 th working day	Adult Weight Management Service
Exception report to be provided (when appropriate) quarterly for any patient going over 12 months in the applicable three month period – these patients will have a review and the decision justified clinically.	Quarterly	For local agreement	Quarter one – by 31.08.2017 Quarter two – by 30.11.2017 Quarter three – 28.02.2018 Quarter four - 31.05.2018	Adult Weight Management Service

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Service Specification No.	CS_29
Service	Track and Triage Service
Commissioner Lead	Natalie Cotton
Provider Lead	Christine Wheeler / Lisa Agell
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

Staffordshire Health Economy comprises of two local authorities, six Clinical Commissioning Groups, who are responsible for buying healthcare for the area, and five NHS trusts providing services to 1.1 million people.

Our population needs are changing as people live longer, often with more complex conditions. Over the next 20 years, from 2010 to 2030, the number of people aged 65 and over is expected to increase. This will have an impact on the numbers of people experiencing long term conditions and who will be in need of health and social care. This increase has important implications for health and care delivery from both a financial and activity perspective
By 2021 the number of people aged 65+ will rise by 16%.

- 800 patients are admitted to our local hospitals every day
- 330 of these admissions are unplanned
- 60 patients are readmitted within 30 days of discharge
- 33% of people in a hospital bed at any at any one time could be treated better elsewhere
- 30% of acute bed occupancy is by those with mental health needs

A significant amount of work has been undertaken to improve access and capacity across the health economy, developing services to meet potential demand and supporting a co-ordinated approach to patient pathway navigation. As part of this work accessibility and effectiveness of admission prevention and discharge has been identified as an integral element of success. The key principle is that people will be supported at Home First whether as part of hospital discharge or admission prevention.

Staffordshire Health Economy have agreed to implement a 'discharge to assess' approach. People who have completed their episode of acute care and need some further support will be transferred to an appropriate discharge service, for short period for further reablement and rehabilitation as well as assessment of long-term care needs if necessary.

The planning assumption is that 10% of all adults discharged from acute hospitals will require a discharge to assess service, and that the remaining 90% will be discharged home with no support or back to a previous care package or placement without assessment.

The 'Home First' approach will also be supported by diverting people away from acute hospital admission wherever possible into admission prevention services.

Track and triage will be used for admission prevention and for discharge to assess to support the 'home first' approach.

The specification outlines an approach to support effective management of hospital discharge and admission prevention services to support patients at the most appropriate level and setting for a their needs

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

This Provider will be required to meet the NHS Outcomes Framework Domains as detailed below.

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

2.2 Locally Defined Outcomes

- Admission prevention, via effective assessment, referral, and signposting
- To deliver patient-centred, safe and timely transfers of care and ensure an improved patient experience.
- A reduction in delayed transfers of care, for patients requiring supported discharge.
- Reduction in length of stay
- To provide validated, real time capacity and demand information across the LHE.
- Provision of daily Local Health Economy information as required to support decision making
- To increase the levels of self-care and interventions within a setting as close to the home environment as possible
- Delivering high quality, safe and clinical sustainable services which meet required standards of care and are safe 24/7 supporting individuals at the at the most appropriate level and setting for their clinical need
- Ensuring patients have access to the right care in the right place at the right time where capacity is available.
- Connecting urgent and community care services together more efficiently to reduce a fragmented and complex system
- Support patient flow to enable best use of the economy's resources
- Improved patient experience and outcomes

3. Scope

3.1 Aims and Objectives of Service

The key principle of the service is that people will be supported at Home First whether as part of hospital discharge or admission prevention. The specification brings together the current track and triage service and intermediate care referral line under a single specification supporting effective management of hospital discharge and admission prevention services based on the most appropriate level and setting for a patient's needs.

The service shall:

- Prevent acute hospital admissions when appropriate or not required
- Allow timely discharge of people from acute hospitals once they have completed their episode of acute care
- Effectively manage capacity in hospital discharge and admission prevention services so that people get the right care at the right time
- Support the active rehabilitation and reablement of people wherever possible so that they can return to full independence
- Support reductions in the number of assessments for long term care
- Support reductions in the number of people who may require ongoing long-term care

3.2 Service description/care pathway

The service will deliver the subsequent functions:

- A single point of access
- A multidisciplinary led service that facilitates both entry and exit into health and social care services
- Local Health Economy capacity demand and capacity reporting to support management and coordination of the Local Health Economy System.
- Support access to ICT by local care homes both proactively and reactively, supporting clinical interventions, advice and guidance as required
- The provider will be responsible for any subcontracting arrangements for shared IT systems

Referrals will be accepted from GPs (via the Intermediate Care referral line), Front of House, Emergency Portals, in-patient wards, local care homes, 111 and WMAS.

The service model will comprise the following:

Triage team

The provider will ensure that there is a single triage point supporting the Local Health Economy to manage patients who present at an emergency portal or from the community who do not require an acute admission and facilitate in-patient discharges when patients no longer require an acute bed.

The Integrated Triage Team will provide one integrated point of referral for all people that present from the community, an acute hospital including A&E, other portals such as AMU/FEAU and for in-patient wards. The Triage Team will sit alongside the Track Team and all functions will be fully aligned across the two.

The Triage team will determine where people that are deemed to have complex needs within either the acute setting or from the community are supported to access rehabilitation, enablement, care and support and an assessment of their long term needs where required.

The team will be made up of a highly skilled multi-professional group of staff who have expertise and knowledge of the functions of community services and can manage patients in a safe and effective way supporting both health and social care needs.

The team will receive the Patient Profile and, using this, determine whether the person will go home or to a commissioned bed in either a community hospital or care home (dependent on local commissioned capacity), or remain in their appropriate care setting with additional identified support.

The team will ensure that there is a clear understanding of the service user/patients immediate needs for care and support. Information will be documented clearly and passed on to the receiving team to provide a clear understanding of the needs to enable provision of safe and effective care and support.

The referral to the Triage Team will be monitored by the Track Team and will meet the requirement under the care Act of a 'Notification' where that is needed. The team will respond to all referrals on a same day basis and this will be monitored via the Track Team.

The team will also undertake assessments by exception linked to:

- Front of House referrals and requirements
- In portals to avoid admission as an in-patient
- People with highly complex needs and who cannot be safely discharged without an assessment being completed e.g. people with a significant cognitive impairment requiring complex Best Interest Decision making.

The team shall:

- Receive all complex in-patient referrals and manage the initial determination of next steps
- Manage the formal 'Notification' as required under the Care Act (2014)
- Receive the Patient Profile and challenging the quality of the information where appropriate
- Link with the Front of House team
- Critical link into community-based services to ensure that all services are mobilised to support discharge as required
- Critical link with commissioned beds
- Manage the Trusted Assessor and transfer processes
- Critical link with wards to ensure that the Choice Policy is fully implemented
- Receive and manage all referrals linked to admission avoidance that would usually be supported by Intermediate Care
- Support assessment in:
 - Front of House
 - Portals
 - By exception to wards
 - High Intensity Users Project –
- Referral triaged and decision made within one hour of receipt – home or bed
- Information shared with receiving team/service and discharge details confirmed with both receiving service and ward/portal – within 2 hours of receipt
- Discharge confirmed and arranged within 3 hours of receipt
- Aim for same day discharge dependent on time of referral
 - Prior to 2pm – same day
 - After 2pm – next day
- Response for admission prevention
 - Prior to 6pm - same day
 - After 6pm - patients will be safely supported to remain in their home until the next day if appropriate

Track team

Triage will be supported by a team that will effectively track people through the system once they have become known.

The Track Team will provide one integrated point of referral, patient tracking and Local Health Economy information flow to include home and bed-based services.

The track team shall coordinate the flow of information for the local health economies across Staffordshire And Stoke on Trent. Once the team have been informed that a patient has presented to either an emergency portal or from community crisis, the team will start to track the patient's journey.

The team will support the monitoring of unmet demand across the system and provide appropriate information as required.

The Team shall:

- Receive all complex referrals and managing flow to triage team – with all data tracking adding to the commissioned IT tracking system in use. Based with triage team on site
- Manage information on flow of all patients to new Discharge to Assess (D2A) services and those for assessment on site
- Support FOH with data collection and management of the Patient Profile into the tracking system and tracking this through whole patient journey
- Track the patient journey through FOH (Front of House), portals and in-patient beds
- Track patients within the new D2A service – overarching tracking only – local teams will hold daily management of inputting – reporting will be via the track team
- Management and flow in CCG commissioned beds
- Management and flow in non-acute hospital sites
- Provide a patient flow link to MDT within bed based services
- Demand and Capacity reporting for LHE system wide
- Reporting of external partners capacity such as care homes, domiciliary care providers
- D2A capacity reporting for LHE system wide – Home and Bed services
- Dual brokerage service into the D2A capacity alongside triage team
- LHE data collection for conference calls
- Report to LHE re complex movement as agreed locally within each LHE as agreed – new reporting to be in place with function
- Delayed Transfers of Care (DToC) reporting both within the hospitals and all new D2A services
- All Out of area patient flow into complex teams – chase and monitoring
- Escalation management and monitoring alongside current EMS level reporting and each organisations escalation plan
- Monitor capacity flow reporting – via local process and national tools (OPEL)
- Escalation management to relevant organisations
- Oversight of Transport arrangements to support discharge. Ability to challenge where this is causing delays
- Ensure that the Patient Profile is maintained and updated on the appropriate tracking system
- Have effective electronic systems in place to manage data and support analysis to inform the LHE.
- To provide the analysis and have skills to respond to ad hoc requests as received

Hours of operation

The service will operate between the hours of:

Royal Stoke University Hospital - 8am to 8pm, 7 days per week for 365 days of the year

County Hospital Stafford – 9am – 6pm, 7 days per week for 365 days of the year

- discharge dependent on time of referral
 - Prior to 2pm – same day
 - After 2pm – next day
- Referrals for admission prevention
 - Prior to 6pm - same day
 - After 6pm - patients will be safely supported to remain in their home until the next day if appropriate

3.3 Clinical Governance

Clinical Governance arrangements will include:

- The Provider must have their own clinical governance arrangements to include; incident reporting, adverse/serious incident reporting (including the management and lessons learnt), managing alerts, compliance with national/local standards including NICE, compliance with local and national audits and the effective handling of complaints.
- Clear and well-publicised routes for service users and health professionals to feedback their experience of the service, ensuring prompt and appropriate response to that feedback with shared learning between organisations, including feedback to the individual who was the source of the comment.

- Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the service.
- Regular staff training and refreshing where required on updated policies and procedures, to ensure quality of service is maintained.
- Provision of accurate, appropriate, clinically relevant and timely data about the service to ensure that it is meeting the quality standards set out in this specification.
- Regular clinical review of the quality of referrals especially where they have been problematic, with involvement of other partner providers

3.4 Population Covered

The service shall be available to adult patients registered with a GP Practice within North Staffordshire, Stoke on Trent, Cannock Chase, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds Clinical Commissioning Groups (CCGs).

For patients who do not reside within the CCGs above, the service will develop, where possible and appropriate, supporting pathways to facilitate timely discharge for patients from acute hospitals once they have completed their episode of acute care

3.5 Any acceptance and exclusion criteria and thresholds

The model will support the following people either being discharged from acute hospitals or as part of admission prevention:

- People with sub-acute health needs who do not need an acute admission
- People who following an acute admission will benefit from short term interventions to maximise their independence.
- People who following an acute admission need a period of ongoing support whilst their long-term care needs are assessed.
- People being discharged on specific pathways such as the orthopaedic pathway.
- People at the end of their lives who need ongoing care and support.

Exclusions

- Patients identified as having acute needs which cannot be managed within a community setting
- Discharges that can be supported via more appropriate services e.g. Stroke – Early Supported Discharge
- Patients who require longer term interventions and rehabilitation

3.6 Interdependencies with other services

- GP practices
- UHNM
- Stoke on Trent City Council
- Staffordshire County Council
- Front of House
- The Voluntary Sector
- Integrated Local Care Teams
- Nursing and Residential Homes
- The Integrated Community Equipment Service
- End of Life Services
- Hospices
- WMAS
- PTS

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

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

Refer to Schedule 4 Parts A-D within the main contract.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Refer to Schedule 4 Part D within the main contract
6. Location of Provider Premises
7. Individual Service User Placement
Not applicable

Service Specification No.	CS_30
Service	Tissue Viability - Cannock Chase & Stafford & Surrounds Clinical Commissioning Groups
Commissioner Lead	Simon Runnett
Provider Lead	Ian Turner
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

1.1.1 General Overview

The increasing age profile of the local population and the increase in prevalence of diabetes along with the continuing high prevalence of pressure ulcers means that addressing wound healing problems is a key element of patient care and prevention of admission to acute settings.

Pressure ulcers are recognised as a key quality indicator and national and regional policy requires the elimination of avoidable Grade 2, 3 and 4 pressure ulcers.

There is an increase in complexity of patients whose wound care is managed in the community, who would previously have been managed in acute settings.

There are an estimated 180,000 newly acquired pressure ulcers developing each year in the NHS (NHS Safety Thermometer 2012) and in 2011 the National Reporting and Learning System received 91,810 pressure ulcer related patient safety incident reports, making pressure ulcer prevention one of the biggest patient safety challenges facing the NHS (ref Patient Safety First).

As well as causing long term pain and distress for patients, treatment is estimated to cost the NHS between £1.4 and £2.1 billion per year (Bennett et al). However, evidence indicates that the majority of pressure ulcers are preventable and could be avoided through simple actions by staff, patients and carers.

NHS Right Care scenario: The variation between sub-optimal and optimal pathways

<https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/nhs-rightcare-bettys-story-narrative-full.pdf>

Betty's story: Leg ulcer wound care

1.1.2 Evidence Base

A recent research study has estimated that the annual cost of managing wounds in the NHS and associated comorbidities is £5.3 billion. This is comparable to the £5 billion spent on managing obesity in the NHS. Over a year approximately 4.5% or 2.2 million people of the UK adult population will have a wound and about 30% of wounds in this study lacked a diagnosis documented in the GP records.

In the UK most wounds are managed largely in the community by GPs and more commonly by nurses. The most commonly treated wounds are leg ulcers. Leg ulcers are chronic wounds that occur in the lower leg; they are distressing and painful to those who have them, prone to infection and have a negative impact upon a patient's mobility and quality of life.

1.5% of the UK population (with wounds) are estimated to have a leg ulcer and 19% of the leg ulcers in this research study were not characterised. To ensure the most appropriate treatment, the 'character' of leg ulcers needs to be diagnosed to determine the predominant cause, such as venous, arterial or mixed aetiology.

Improved wound care including effective assessment, diagnosis, treatment and prevention of wound care complications can minimise treatment costs and importantly improve outcomes and experience for people with a wound.

NHS Benchmarking

NHS Benchmarking have reported that in the 2016 annual audit of district nursing activity, 39% of clinical time by the service is spent in wound care. The detail for leg ulcer care is not available. An estimate can be made using additional research which suggested that 20% of the wound care work was venous leg ulcers. Therefore approximately 8% of the whole district nursing workforce time is spent on venous leg ulcers and 2.1 million visits annually.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

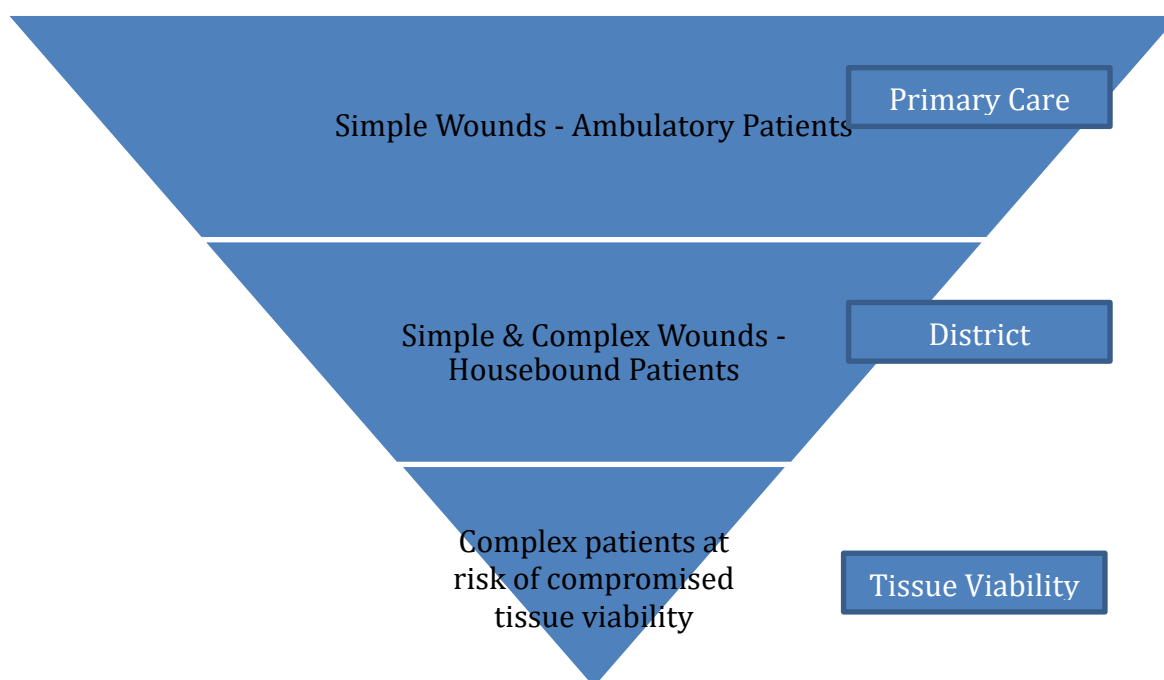
Domain 1	Preventing people from dying prematurely	Y
Domain 2	Enhancing quality of life for people with long-term conditions	Y
Domain 3	Helping people to recover from episodes of ill-health or following injury	Y
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring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

2.2 Expected Outcomes

- The provision of a seamless service that is accessible and delivers a safe and equitable service across the patient journey.
- Avoidance of admissions to hospitals for patients with complex tissue viability care needs.
- Enhancement of the educational and professional development of roles within the specialist team.
- Improvement in the provision and uptake of training and education for healthcare staff i.e. primary care, community services and nursing/residential homes.
- Reduction in the incidence of avoidable pressure ulcers developing or deteriorating in patients cared for by staff employed by SSOTP.
- Continuous quality improvements are driven through the service with a focus on prevention.

2.3 Service Model

The success of the service is based on a tiered approach to delivery of Wound Care which relies on partners to undertake the necessary interventions in a timely way and allow Step Up/Down between services appropriate to assessed level of need. Appendix 2 and 3 outline the responsibilities of General Practice and District Nursing in relation to this model:



The service will operate Monday to Friday between 09.00 and 17.00, with clear lines of responsibility for strategic management and clinical leadership. No out of hours support is available as this is not an emergency service.

The service will provide a comprehensive, patient-centred Specialist Tissue Viability Service in the community, which delivers high quality, efficient services in line with national guidance and local requirements and which achieves the best health and well-being outcomes for all patients with/ or at risk of, compromised tissue viability.

This includes the provision of education, advice and training to staff who manage patients in the community (e.g. District Nurses and Practice Nurses) so they can initiate treatment quickly which can prevent a patient's condition worsening, alleviate discomfort, relieve distress and the need for possible hospital admission, and to offer advice and support to patients residing in care homes with nursing and practice nurses across Cannock Chase & Stafford & Surrounds general practices.

3. Scope

3.1 Aims of service

To provide a specialist service that achieves good patient-centred, safe and integrated care.

The service aims to improve the health outcomes of the target populations and provide:

- Specialist advice
- High quality and safe care
- Evidence based interventions
- Good access to services
- Equity and fairness
- Responsive patient centred care
- Education
- Efficient use of resources
- An increase in the number of patients cured or symptoms alleviated
- Appropriate use of the SSOTP service specific Wound Care Formulary;
<http://www.staffordshireandstokeontrent.nhs.uk/Wound%20Care%20Formulary%202012.pdf>

Staffordshire and Stoke on Trent Partnership Trust (SSOTP) Tissue Viability Service (TVS) have developed a robust, evidenced based and concise Wound Care Formulary.

The formulary is designed to support nurses in their decision making process in the area of wound care. The formulary will be subject to review and a mechanism for comments and the assessment of new products will be ongoing. Any products which are identified as like for like, after going through a robust evaluation process and agreed with respective partners will be changed over if cost savings can be identified.

The Formulary should not be used in isolation and should not replace sound clinical judgement. Practitioners with specialist wound care knowledge should be referred to if necessary.

There are three sections to the Formulary:

- The **GREEN** section which is available for all community staff to prescribe.
- The **AMBER** section which staff will be able to prescribe with the use of the Exemption Form
- The **RED** section is to be used in conjunction with Tissue Viability Guidance

We need to focus on Primary Care providing a minimum standard of wound care across practices to enable District Nursing teams to focus primarily on the housebound patients, and the Specialist Tissue Viability Service to focus on the more complex patients.

Rather than episodic care, clinicians are expected to have a shared responsibility for the clinical outcomes across the health economy.

3.2 Objectives

The overall objectives of the service are:

- To deliver patient centred care through integrated service delivery across the local health economy (e.g. shared management plans)
- To provide timely optimal wound healing with clear step-up and step-down guidance
- To support an improvement in detection to prevent the development of long term conditions such as leg ulceration (e.g. through the use of Doppler assessments).
- To support a reduction in outpatient attendances by providing advanced diagnostic skills within the clinic or home setting in relation to leg ulceration.
- To promote a greater use of clinics in the community for those that are able to leave the home (with the support of friends/relatives or [community transport options](#)), leaving home visits for the truly housebound.
- To support a reduction in health care costs related to prescribing advanced diagnostic skills and treatments.
- To support a reduction in use of wound care products by the use, dissemination and monitoring of the wound care formulary.
- To improve communication with Social Care, MASH and private care homes (care homes with nursing and residential homes) sharing of information, training and reporting of suspected adult abuse/ safeguarding issues.
- To support the prevention and management of patients with complex needs in relation to:
 - Pressure ulcers or pressure ulcer prevention.

- Ulceration of the leg.
- Ulceration associated with lymphoedema and their management (this does not include the management of complex lymphoedema).
- To move away from a 50 percentage patient facing model towards less patient facing time, with a greater proportion of their expert time being spent on educational activities across Primary Care, Community District Nursing and nursing and residential homes.

3.3 Service Description/Care Pathway

3.3.1 Service Description

The service will provide:

- Education and training in wound prevention and wound care to healthcare and social care community staff, including practice nurses (with some education and training programmes for nursing and residential homes).
- Instruction, evaluation and where necessary the provision of complex therapies including sharp debridement.
- Advice and treatment for non-healing wounds including leg ulcers and pressure ulcers referred from District Nurses as part of chronic wound care
- Comprehensive clinical audit in relation to all aspects of tissue viability activity and standards within District Nursing teams to ensure the NICE standards are adhered to.
- Support in clinical practice and policy development.
- Management of the link nurse champion system across the health economy.
- Procurement advice to the Trust.
- Research and development in tissue viability.
- A Contribution to a reduction in expenditure on wound care dressings by the implementation and updating of the wound care formulary and the implementation of first dressing initiative.
- A tissue viability service to care homes with nursing within current capacity available. This may be facilitated by sharing policies and offering group training and developing the role of the link nurse in homes.
- The development of a managed Topical Negative Pressure (TNP) therapy service which will offer a cost effective, clinically effective service to facilitate discharges from and prevent admissions to hospitals.
- Advice and support on grade 3 and 4 pressure ulcers.
- Direct access to health education and support by the provision of educational programmes for patients, carers and staff, this includes the provision of a specialist equipment service aimed at the prevention and treatment of pressure ulcers.
- Signposting to other organisations such as Social Care, the Police service, care homes with nursing and residential homes and private care homes to existing training opportunities; this would cover the sharing of information, training and reporting of suspected adult abuse.
- Support for pathways in relation to the management of the diabetic foot ulcer, leg ulceration, pressure ulcers and complex wounds.
- Support for the management of patients with wounds of complex aetiology such as malignant wounds, burns, sinuses or fistulas
- Support for the management of all patients with chronic non-healing wounds leading to an improvement in quality of life or healing
- Effective management within the community setting of those patients requiring complex interventions such as TNP therapy, debridement, grafts and expensive non drug tariff wound care products.
- Participation in a reflective review and root cause analysis of all patients developing grade 3-4 pressure ulcers (European Pressure Ulcer Advisory Panel – EPUAP) whilst under the care of the District Nursing service, this does not include patients residing in care homes with nursing or patients discharged from secondary care). This review is a requirement of NICE guidelines.

It is expected that the specialist team will operate within a clinical governance framework for the delivery of all the required interventions as defined by the following:

- Clear lines of responsibility and accountability
- Clinical audit processes
- Evidence-based practice delivered with cost and clinical effectiveness
- Ensuring risk management mechanisms are in place and safety is a clear priority
- Ensuring continuing professional development programmes are in place
- Patient focus with accessible and responsive care.

3.3.2 Care Pathway

A Step-up and Step Down approach should be used across Primary Care, the District Nursing Service and the Specialist Tissue Viability Service. Pathways are described in Appendix 2, 3, 5 and 6.

3.3.3 Discharge Criteria & Planning

Discharge planning will be included as an integral part of the patient's care plan from initial assessment and referral into the service. This planning will be completed in collaboration with other members of the multi-disciplinary team involved in the patient's care and they will be discharged back to the care of the relevant healthcare professional responsible for their care.

The criteria for discharge from the service will usually be when optimal skin integrity is achieved or treatment is completed, or when an onward referral is required to other specialist service as per the pathway.

Referral can be made back into the Tissue Viability service if the patient's condition changes or deteriorates significantly.

3.3.4 Self-Care and Patient and Carer Information

Patients and carers are offered education, information and support through face to face or telephone consultations. Details of appropriate web sites will be given to patients and literature in the appropriate language is offered.

Written self-care information and user instructions are given to patients and carers on specific equipment and treatments with relevant contact details and useful information.

Health promotion material is given specific to the condition of the patient.

3.4 Population covered

The service is provided for the entire registered population of Cannock Chase and Stafford and Surrounds Clinical Commissioning Groups.

Adults and children with a wound or tissue viability condition (not including inpatient mental health patients). Some children will be seen by the Childrens' Community Nursing team, and adults (18+) will be seen by the District Nursing service. There will be open dialogue with the patient and between the Childrens' Community Nursing team and the District Nursing service to determine the most appropriate nursing service to meet their nursing need.

The Specialist Tissue Viability Service will support mainly adults, but on occasion supports some children in partnership with the Childrens' Community Nursing team.

The service provider(s) is expected to treat patients in the appropriate location based on assessed need.

3.5 Any acceptance and exclusion criteria and thresholds

3.5.1 Referral Criteria and Source

The following patients can be referred to the Tissue Viability Service:

- Patients with complex wounds
- Patients with grade 3 or 4 pressure ulcers
- Patients deemed to be very high risk of pressure ulceration and staff who may require additional advice, such as patients with multiple complex needs
- Patients requiring complex therapies ie. Negative Pressure wound therapy, PICO, larvae or Cures or requiring sharp debridement.

The following people can access the **advice** offered by the Tissue Viability Service:

- All staff employed by SSOTP
- Nursing and residential homes via their designated tissue viability lead
- Practice nurses and GPs

Patients can be referred by:

- Registered nurses / AHPs / Medical staff within wards
- Registered nurses / AHPs / Medical staff within A&E
- District Nurses/community nurses
- Nursing and homes managers

3.5.2 Referral Route

Patients can be referred by Phone, Fax or Email. A Specialist Tissue Viability Nurse will triage the patient and decide on the level of priority and /or urgency. There is a standardised referral form to access the service. The team will use a Step-up and Step-down model and will step patients down when it is clinically safe to do so.

3.5.3 Exclusion Criteria

The following patients are excluded from the service:

- Patients with a non-complex acute wound that heals within 4-6 weeks
- Patients with pressure ulcers less than grade 3 unless they have complex needs
- Patients residing in nursing homes with leg ulceration (although professional advice can be sought from the team)

There are no exclusions for health and social care professionals seeking advice.

3.6 Interdependence with other services/providers

3.6.1 Whole System Relationships

The service will work as a completely integrated system. This service is embedded in the local community. The provider will be expected to have a relationship with all elements of primary care, secondary care, the local authority and the voluntary sector:

Primary Care – integral to the team

Secondary Care – Integral to the team

Social Care – Good working relationships to help facilitate communication and discharge and admission where necessary to hospitals.

Voluntary Sector – Good working relationships to help facilitate communication in order to support the implementation of packages of care where appropriate.

Safeguarding

The service must also ensure that policies and procedures in relation to safeguarding are adhered to and that it seeks the advice as necessary. Reference should be made to the safeguarding clauses within the main body of the contract.

3.6.2 Interdependencies

- Allied health care professionals (e.g Occupational therapists, physiotherapists, speech and language therapist , podiatrist and dieticians)
- General Practitioners
- Hospital medical staff
- Specialist nurses
- Other statutory and non-statutory agencies
- Hospices/ palliative care services
- District nurses
- Care homes with nursing staff and management
- Residential home staff and management
- Social care team
- Safeguarding teams - MASH
- Discharge liaison services
- Practice nurses
- Community health care coordinators
- Specialist Tissue Viability nurses within secondary care
- Vascular medical and nursing staff within secondary care
- Patients and the public

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Clinical practice guidelines – the management of patients with venous leg ulcers

https://www2.rcn.org.uk/_data/assets/pdf_file/0004/107941/001269.pdf

Pressure ulcers: prevention and management <https://www.nice.org.uk/guidance/cg179>

Best practice statement – Care of the Older Person's Skin <http://www.wounds-uk.com/best-practice-statements/care-of-the-older-persons-skin-best-practice-statement-second-edition>

Management of patients with venous leg ulcer: challenges and current best practice
<http://www.aiuc.it/files/EWMAvenouslegulcers.pdf>

Simplifying venous leg ulcer management <http://www.woundsinternational.com/consensus-documents/view/simplifying-venous-leg-ulcer-management>

Best practice statement – holistic management of venous leg ulceration <https://www.wounds-uk.com/best-practice-statements/best-practice-statement-holistic-management-of-venous-leg-ulceration>

Optimising venous leg ulcer services in a changing NHS <http://www.wounds-uk.com/supplements/optimising-venous-leg-ulcer-services-in-a-changing-nhs-a-uk-consensus>

Best practice statement – The use of topical antimicrobial agents in wound management <http://www.wounds-uk.com/best-practice-statements/best-practice-statement-optimising-wound-care>

Surgical site infections: prevention and treatment -<https://www.nice.org.uk/guidance/ta24>

Diabetic Foot problems – prevention and management <https://www.nice.org.uk/guidance/ng19>

The guidance detailed above is not exhaustive and the service will be expected to work to new and emerging policy guidance such as that developed by NICE, DH and European Pressure Ulcer Guidance.

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

4.3 Applicable local standards
N/A

5. Applicable quality requirements and CQUIN goals

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

Schedule 4 Quality Requirements C Local Quality Requirements

Ref	Quality Requirement	Threshold	Method of measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
	Educational programme - to ensure an educational programme covering wound assessment, lower limb and pressure ulcers is in place to meet the capacity within the Partnership Trust	85% attendance	at least 4 face to face sessions each month	GC9 Contract Management	To be described in Quarterly reports	Tissue Viability - Cannock Chase & Stafford & Surrounds Clinical Commissioning Groups
	Educational programme - to ensure an educational programme is in place for health economy Partners (Care homes, Primary Care and Private Organisations)	85% attendance	at least 2 sessions each month	GC9 Contract Management	To be described in Quarterly reports	Tissue Viability - Cannock Chase & Stafford & Surrounds Clinical Commissioning Groups
	Link worker programme	4 meetings	4 Link worker Face to face meetings/conferences each year for Partnership trust staff	GC9 Contract Management	2 meetings/conferences to be reported on every 6 months	Tissue Viability - Cannock Chase & Stafford & Surrounds Clinical Commissioning Groups
	Link worker programme	4 meetings	4 Link worker Face to Face meetings/ conferences each year for Primary Care and Care Home staff	GC9 Contract Management	2 meetings/conferences to be reported on every 6 months	Tissue Viability - Cannock Chase & Stafford & Surrounds Clinical Commissioning Groups
	Tissue Viability Service audit	4 audits	To take part in 4 clinical audits each year measuring compliance with policy and best practice, audit reports to be made available to commissioners	GC9 Contract Management	2 audits to be reported on every 6 months	Tissue Viability - Cannock Chase & Stafford & Surrounds Clinical Commissioning Groups

Schedule 6 Contract Management, Reporting and Information Requirements A Reporting Requirements

Ref	Reporting Requirements	Reporting Period	Format of Report	Timing and Method for delivery of Report
	Breakdown of all referrals	Quarterly	To include the source of the referral, Partnership trust staff, Primary Care or Care home	Quarterly
	Educational programme - to ensure an educational programme covering wound assessment, lower limb and pressure ulcers is in place to meet the capacity within the Partnership Trust	Quarterly	To establish a baseline on uptake of an e learning option within Partnership Trust	Record number of staff that have undertaken, and report quarterly
	Educational programme - to ensure an educational programme is in place for health economy Partners (Care homes, Primary Care and Private Organisations)	Quarterly	To establish a baseline on uptake of an e learning option	Record number of staff that have undertaken (including which Partners they are employed by), and report quarterly

5.2 Applicable CQUIN goals (See Schedule 4 Part D)

Improving the Assessment of Wounds (Chronic Wound) – National CQUIN

6. Location of Provider Premises

GP practices are based in a variety of locations across the CCG areas. Community District Nursing teams are based in a variety of locations both in MPFT premises, GP practices, council offices, fire stations.

The Specialist Tissue Viability Team are located at Springfields Health and Well Being Centre; off Lovatt Court, Rugeley WS15 2FH

7. Individual Service User Placement

N/A

Service Specification No.	CS_31
Service	Integrated Specialist Long Term Conditions Service
Commissioner Lead	
Provider Lead	Karen Dawson- Midland Partnership NHS Foundation Trust
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

National context

15.4 million people in England (over a quarter of the population) have a long term condition (LTC), and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million in 2018). People with long term conditions use a significant proportion of health care services (50% of all GP appointments and 70% of days spent in hospital beds), and their care absorbs 70% of hospital and primary care budgets in England.

NHS England state that “the NHS should be supporting people to be as independent and healthy as possible if they live with a long-term condition such as heart disease, asthma or depression, preventing complications and the need to go into hospital. If they do need to be treated in hospital, the NHS should work with social care and other services to ensure that people are supported to leave hospital and recover in the community”.

NHS England has identified specific outcomes within the NHS Outcomes Framework Document and specifically Domain 2 relates to long term conditions. The identified a set of key areas for action are:

- Helping patients take charge of their care
- Enabling good primary care
- Ensuring continuity of care
- Ensuring a parity of esteem for mental health
- House of Care – a strategic framework for integrated care for people with long term conditions
- Reducing avoidable emergency admissions

Local Context

There is good evidence that our care of people with LTCs can be improved. Patients tell us that they want to do more to support their own self-care. Holistic care planning is a systematic way to put self-management into practice. The 2015/16 NHS England LTC Dashboard tells us that of the percentage of patients recorded with a long term condition, 7.86% in Stoke on Trent and 7.5% in North Staffs report having a written care plan. Of the cohort that recognise having a written care plan 61.8% in Stoke on Trent and 61.9% in North Staffs report that they use their care plan in the day to day management of their long term condition. This clearly demonstrates that although only a small number of patients recognise having a care plan, for those who are aware of their care plan, a greater proportion use them daily to help manage their condition.

Table 1 below illustrates the recorded prevalence against the expected prevalence of diabetes, respiratory conditions and heart failure

Table 1: Recorded Prevalence of Diabetes, Respiratory Conditions and Heart Failure for 2016/17

Condition	Recorded Prevalence		Expected Prevalence	
	Stoke-on-Trent CCG	North Staffordshire CCG	Stoke-on-Trent CCG	North Staffordshire CCG
COPD (All age)	7165 (2.5%)	5102 (2.3%)	7235 (2.6%)	6111 (3%)
Asthma (All age)	17841 (6.2%)	13889 (6.4%)	24993 (9.1%)	18674 (9.2%)
Diabetes (17+)	18039 (7.9%)	13446 (7.4%)	12953 (5.9%)	10988 (6.6%)
Heart Failure (All age)	2379 (0.8%)	1849 (0.8%)	4041 (1.5%)	3641 (1.8%)

Total	45424	34286	49222	39414

Source: Quality and Outcomes Framework 2016-17 - Recorded disease prevalence, achievements and exceptions
Clinical Commissioning Group (CCG) level
Link to publication: <http://digital.nhs.uk/pubs/qof1617>

Table 2 illustrates the number of patients being admitted with a primary diagnosis of Diabetes, Respiratory Conditions and Heart Failure during the period August 2017 to end of July 2018.

Table 2: Number of admissions for the period 2017/18 (Adults only)

Condition	Number of admissions		Percentage of all ACS admissions	
	Stoke-on-Trent CCG	North Staffordshire CCG	Stoke-on-Trent CCG	North Staffordshire CCG
COPD	906	476	16.07%	12.86%
Asthma	297	164	5.27%	4.43%
Diabetes	531	335	9.42%	9.05%
Heart Failure	256	207	4.54%	5.59%
Total	1990	1182	35.30%	31.93%

Source: Business Intelligence, Midlands and Lancashire Commissioning Support Unit
ACS report on Aristotle

In addition, the number of patients with 1 or more LTC is adding to the complexity, which is reflected both nationally and locally. Table 3 illustrates the percentage of patients who have 1 or more long term conditions.

Table 3: Percentage of patients with 1 or more LTCs

	Stoke-on-Trent CCG	North Staffordshire CCG
1 LTCs	30.6%	30.5%
2 LTCs	13.8%	15.5%
3 or more LTCs	13.12%	12.16%

Source: NHS England LTC Dashboard (2015/16)

An added complication for these patients is the number of them that also experience mental health problems associated with their long term conditions. Table 4 illustrates the percentage of patients with LTCs reporting mental health problems during the GP survey.

Table 4: Percentage of patients with LTCs reporting Mental Health problems

Organisation	% of patients recorded with a LTC who report having a mental health problem
Stoke-on-Trent CCG	7.95%
North Staffordshire CCG	6.30%

Source: NHS England LTC Dashboard (2015/16)

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

- Increased identification of long term conditions in Primary Care;
- Contribute to a reduction in avoidable emergency hospital admissions;
- Contribute to a reduction in length of stay;
- Improved quality of life for patients long term conditions;
- Increased self-management;
- Increased number on appropriate therapy;
- Support in increasing annual reviews of patients with long term conditions in primary care;
- Support the development of Primary Care staff to appropriately care for people with LTCs including community nursing, practice nursing and general practice;
- Increasing the number of people with holistic personalised care plans to support and increase confidence to self-manage;
- Increase in the numbers of patients assessed for mental health problems and subsequent support offered;
- Reduction in complications resulting from long term conditions;
- Reduction in duplication of appointments for patients with multiple LTCs;
- Increase in % of patients being on general practice EOL register at least 3 months before they die;
- Increase in number of patients who identify themselves as feeling confident to manage their long term condition.

3. Scope

3.1 Aims and Objectives of Service

The overall aim is to achieve a locality-based integrated specialist long term conditions service which drives up clinical outcomes and quality of life for patients and their carers; which is strongly linked into the localities they serve and deliver a reduction in use of secondary care services.

The Provider will aim to deliver a high quality, person-centered service that enables people with long term conditions to manage their condition thereby reducing the incidence of exacerbations which in turn will reduce the number of avoidable non-elective admissions to hospital. The Provider shall deliver a model that meets the needs of the patient rather than being disease specific.

The main conditions identified within the Long Term Conditions service are Diabetes, Heart Failure (all elements) and Respiratory conditions, the Provider should ensure specialist provision in those conditions, however, this list is not exhaustive and the Provider will ensure that they seek support from other specialists should the need arise.

The Provider should recognise that a patient is at the End of Life (EoL) as soon as it is appropriate to do so; share details with the Primary Care team and/or palliative care team to ensure that the patient is entered on to the EoL GSF register to enable efficient co-ordination of EoL care.

Key Principles

The Provider will ensure the following key principles are adopted:

- Services shall be community led, with Consultant support, delivered by specialist nursing to support Primary Care and avoid patients presenting in crisis and presenting as non-elective admissions;
- Operate seamlessly across Primary Care, Secondary Care providing support to Home First Teams, District Nurses, Community Matrons, Practice Nurses and general practice;
- Provide a focus on supporting integrated local working arrangements in Primary care and the developing MCPs / care hubs;
- Contribute to the formulation of a single, holistic care plan, owned by primary care, which pulls together all clinical and social care and voluntary sector contributions and recognises the role the patient/carer has in managing their own care throughout their lifetime. This will recognise multi-morbidity factors to ensure a holistic approach to addressing a patients needs are met;
- Provides a timely, responsive and anticipatory intervention by specialists which will prevent patients reaching crisis point in their condition;
- Promotes self-care and patient education which will equip patients and their carers with the tools to understand and manage their own long term condition;
- Provide support and education to primary care personnel in managing long term conditions;
- Drive continuous improvement in performance of the specialist nursing teams.

The Provider shall:

- Consider and influence strategies to tackle the factors that contribute to the development and exacerbation of long term conditions;
- Co-ordinate the specialist services for patients with long term conditions so that they fit around the needs of the patient;
- Provide high quality long term condition care, as defined by NICE Quality Standards, to all patients covered by this specification;
- Through personalised care planning, empower patients to self-manage their own condition(s);
- Contribute to a reduction in the number of years of life lost for patients with long term conditions;
- Reduce the risk of complications for patients with long term conditions;
- Deliver person-centred outcomes in a timely manner;
- Provide parity of esteem between mental and physical ill health for those with long term conditions by reducing rates of depression, anxiety and self-harm in patients and by increasing the rates of access to psychological therapies for patients with comorbid depression and long term conditions;
- Provide education and support to other healthcare professionals, including Primary Care, to improve the diagnosis rate of long term conditions;
- Provide education and support to primary and community healthcare professionals to develop a more skilled workforce;
- Promote integration of care between all agencies involved in the care of the patient and carer to ensure seamless transfer to care between settings.
- With Primary Care undertake medication review (excludes annual reviews as part of QOF requirements), including initiation, titration and optimisation of medication;
- Respond under patient care plan arrangements and/or at the request of Home First to exacerbations and case management support for complex cases;
- Under the integrated working arrangements, specialist nurses are not expected to be case managers or to hold an individual caseload. The emphasis of the service is on applying clinical judgement for patients whose symptoms suggest an LTC, or in the case of more complex patients, to contribute to and participate in the care plan managed by primary care and provide direct specialist support to Home First teams so that patient health needs can be met in community and home settings.

3.2 Service Description/Care Pathway

The Provider shall deliver an Integrated Specialist Long Term Conditions Service; services shall have a focus on improving patient outcomes and patient engagement by supporting the management of patients with LTCs in the community.

Services shall be community led with Consultant support to ensure clear integration along the care pathway and be aligned to the integrated local working arrangements in Primary Care and the developing MCP's/ care hubs.

The Provider shall ensure that the service is adequately staffed by appropriately qualified personnel in order to ensure patient safety in the delivery an integrated Long Term Condition service.

Where applicable, health technologies such as Florence Telehealth, video consultations, virtual contacts / consultations and apps will be used where the patients' needs will be improved via these methods

4. LTC Specialist Condition Specific Provision

The Provider will ensure that the Integrated Service delivers the following disease-specific interventions.

4.1 Adult Community Diabetes Service

4.1.1 Diabetes Assessment and Management Service

The Provider shall deliver a **Diabetes Assessment and Management Service** for patients experiencing complexities during their diabetes management including:

- Comprehensive acute specialist patient assessment re: suitability for management in the home in partnership with Home First Teams;
- Instigation of acute treatment and intervention in existing treatment for patients referred from Primary Care;
- Agreed care plans to minimise the risk of avoidable admission to hospital;
- Provide education and awareness of poorly controlled diabetes and potential hospital admission, how to manage changes in blood glucose that occur during other illness and to increase understanding of their disease to take more responsibility for their own wellbeing.
- Support Primary Care with the initiation of GLP1 which is classed as being above core GP contract;
- Facilitate referrals to structured education sessions for both Type 1 & 2 Diabetics where appropriate.

The provider will provide a chronic disease management service that will deliver comprehensive specialist patient assessment and treatment. The service will contribute to individualised care / management plans for diabetic patients discharging patients back to primary care when clinically appropriate; crisis management and self-management discussions should form part of the care plan.

The Service will only serve to manage patients for long-term follow up in a minority of cases, or where the patient is being initiated onto new and emerging therapies requiring review as appropriate. For the majority (approximately 80%) of cases it is envisaged that the patient will be seen on average for 3-5 appointments before being discharged back to primary care with a management plan.

4.1.2 Podiatry Service

The service will work in conjunction with a dedicated Specialist Podiatrist or the Podiatry service to ensure complex foot care is provided to diabetic patients. Referrals to the acute Multidisciplinary Foot Care Team will be made where clinically appropriate.

4.2 Respiratory Disease

4.2.1 Chronic Respiratory Disease Assessment and Management Service

The Provider shall deliver a **Chronic Respiratory Disease Assessment and Management Service** for patients, diagnosed with COPD, ILD and asthma, experiencing acute exacerbations which will include provision of:

- Comprehensive specialist patient assessment as per agreed protocols;
- Lung function testing
- Treatment review and sequential trials.

Provision of an **Acute COPD Assessment and Management Service** for patients experiencing acute exacerbations including:

- Comprehensive acute specialist patient assessment re: suitability for management in the home (as per agreed protocol) in partnership with ILCT Teams;
- Instigation of acute treatment;
- Agreed care plans to minimise the risk of avoidable admission to hospital;
- Referral on for additional Services (e.g. Pulmonary rehabilitation/oxygen assessment, psychological support);
- Treatment review as per agreed protocols.

4.2.2 Home Oxygen Assessment and Review Service

Provision of a **Home Oxygen Assessment and Review Service** in line with the National specification to accept all patients who are clinically identified as requiring home oxygen therapy.

Refer to **Appendix A** for a copy of the National Specification.

4.2.4 Pulmonary Rehabilitation Service

Provision of a **Pulmonary Rehabilitation Service** in line with the National Specification (2012) to accept **all** patients who are clinically identified as requiring Pulmonary Rehabilitation as set out in NICE guidance. The service will include:

- Delivery of a rolling 8-week pulmonary rehabilitation programme at satellite community sites to include all elements stated in NICE Guidance.
- Provision of a telephone follow-up assessment with each patient who successfully completes a pulmonary rehabilitation programme. The follow up telephone call should be carried out:
 - At six months post completion;
 - At 12 months post completion.
- Provision of advice and guidance to patients on suitable follow-on Group/Courses including referral to the Lifestyle programme (or suitable alternative).

4.2 Heart Failure

4.3.1 The Provider will ensure that the Integrated Specialist Long Term Conditions Service delivers the following disease-specific interventions for adult heart failure patients (all conditions) irrespective of its casual mechanism (this includes right sided and left sided heart failure):

- Examination and assessment
- Medication review

- Initiation, titration and optimisation of heart failure medication linking closely with primary care and acute hospitals where necessary
- Response to exacerbations and offer case management support for complex cases
- Support and care during palliative phase
- Development and agreement of a management plan with clear follow up arrangements

4.3.2 Non-oral Diuretic Service

Provision of a **Non-oral Diuretic Service** in the community against the following inclusion criteria:

- Decompensated heart failure associated with any of the following despite adherence to oral diuretics;
 - Significant weight gain
 - Increased shortness of breath/Orthopnoea/Paroxysmal Nocturnal Dyspnoea (PND)/New York Heart Classification III/IV
 - Increased peripheral oedema/ascites
 - Clinical signs of fluid overload
 - Signs and symptoms cannot be attributed to any other treatable cause (e.g. uncontrolled atrial fibrillation (AF), bradycardia, sepsis, thyroid disease, anaemia)
- The patient must have adequate social arrangements to manage IV/SC therapy at home
- A detailed patient assessment and risk assessment is required prior to treatment

4.4 Clinical Governance & Consultant Leadership

The Integrated Specialist Long Term Conditions Service shall require robust clinical leadership. Clinical leadership shall be in two forms:

1) Consultant Support:

- Provide clinical governance to the service to ensure safe and effective practice is delivered;
- Provide clinical, strategic and development leadership to the team.
- Support service delivery, co-ordination and overall performance of the team

2) Team Leader will:

- Be responsible for day-to-day service delivery, co-ordination and overall performance of the team.
- Establish links with other key services dealing with long term conditions, including (but not exhaustive):
 - Primary Care;
 - Voluntary Sector services;
 - Developing MCP's / Care Hubs ;
 - Intermediate Care Services;
 - Social Care Services;
 - Community Nursing Services;
 - Secondary care services.
- Support the Consultant Lead;
- Ensure a highly skilled and competent workforce is in place.

4.5 Prevention

The Provider will support Primary Care and contribute to the consideration and influencing of strategies to tackle the factors that contribute to the development and exacerbation of long term conditions such as:

- Encourage the uptake of the influenza vaccine;
- Signpost people; when appropriate; to smoking cessation and weight loss services;
- Understanding where people with alcohol or substance misuse problems can access support;
- Advise patients with suspected hypertension to see their GP;
- Encourage the uptake of the NHS Healthcheck;
- Encourage the uptake of the Lifestyle Programme (or similar);
- Ensure assessment in primary care of mental health problems;
- Provide simple education on healthy eating;
- Encourage uptake of cancer screening programmes;
- Signpost to voluntary sector support and information.
- Use of Personal Health Budgets for Long Term Conditions

4.6 MDT

The integrated service shall participate in multi-disciplinary team activity for each long term condition whenever this occurs and at an appropriate clinical level.

4.7 Early Supportive Discharge Facility

The Provider will ensure the Integrated Specialist Long Term Conditions Service:

- Aligns to the Home First Team to ensure specialist advice and support is available for patients being discharged to the Home First service;
- Ensures the relevant specialist review of patients discharged from the Acute and Community Hospitals within 48 hours of the Trust being informed of discharge, based on clinical judgement, to enable creating/updating their management plan and discharge back to Primary Care or palliative care if appropriate.

4.8 Support to Primary Care

The Provider will ensure the Integrated Specialist Long Term Conditions Service:

- Provides a community-based service;
- Supports the wider primary care team in the identification and management of the defined patient set;
- Contributes to the single care plan to enable management of patients to remain within the Primary Care setting;
- Provides specialist advice and guidance to the wider primary care team;
- Provides specialist advice and guidance to healthcare professionals working in Care Homes and who care for people with long-term conditions;
- Where clinically appropriate, provides direct clinical interventions to complex patients to optimise management of long term conditions through assessment, optimising therapy, patient support, management and education within the Primary Care Practice;
- Supports Primary Care to encourage patients to self-monitor and use technology to improve self-care and early identification and possible self-treatment of exacerbations.
- Ensure patients are referred for a Medicine Use Review by their local pharmacy. Use of Personal Health Budgets for Long Term Conditions

4.9 Support to Community Hospitals and Care Homes

There are no stated exclusions based on the domiciliary status of the patient, therefore the Provider will ensure that the Integrated Specialist Long Term Conditions Service provides specialist advice and support on the management of patients with long term conditions who are inpatients within the Community Hospitals and care homes

4.10 Clinical Psychological provision

The Provider will ensure the provision of clinical psychological support, specifically:

- Educating other members of the team in undertaking assessment for mental health problems;
- Provision of low level interventions for patients who are identified as requiring psychological input working closely with therapy teams referring to IAPT as appropriate;
- Establish linkages between the Integrated Specialist Long Term Conditions Service and IAPT Services.

4.11 Healthcare Professional Education

The Provider will ensure that the Integrated Specialist Long Term Conditions Service:

- Develops **multi-disciplinary education packages/programmes** for supporting staff working in primary and community services and care homes (to be agreed with CCG professionals);
- In conjunction with the CCG provides the education packages/programmes to healthcare professionals detailed above on a rolling programme (with a minimum of quarterly workshops) to include education in all aspects of:
 - Heart Failure management;
 - Respiratory Disease management;
 - Diabetes management;
- Establishes and provides education and awareness to all healthcare professionals within Primary Care;
- Monitors and evaluates the activity and outcomes of the education and training elements of the service.

4.12 Palliative Care Support

The Provider will provide palliative care and end of life care to patients, where appropriate to include:

- Encouraging Primary care to ensure patients at end-stage long term condition or are deemed as requiring only symptomatic and supportive care, are put on their gold standard framework register for palliative care with appropriate medication;
- Provision of specialist treatment to allow patients to stay at home during the end stage of their symptoms.

- Liaison with the Palliative Care Co-ordination Centre or any equivalent service to ensure a multidisciplinary approach and facilitate co-ordination of EoL Services, as appropriate.

4.13 Technology Enabled Care Services (TECS)

The provider shall make use of available health technologies where it is clinically appropriate and where patient experience and health outcomes can be improved.

4.14 Response Times

As the primary focus is for the Integrated Specialist Long Term Conditions Service to be locality-based, referrals are expected to be minimal. However, where referral from a healthcare professional is received, the Provider will respond within the following timeframes:

- Referral for exacerbations – within 24 hours of referral (unless clinically urgent, where clinical judgement is required – 2 hour response required);
- Referral for advice and guidance from healthcare professionals – within 72 hours of referral;
- Discharge from hospital – within 48 hours of discharge, clinical judgement required.

It is recognised that outside of the services core operational hours an initial response may not be provided by the Specialist Nurse to meet these timeframes. It is expected that although a response may have been provided by an alternative service follow up to ascertain whether the patient requires specialist input will be made by the specialist teams on the proceeding working day.

3.3 Population Covered

The Service is open to all adults aged 18 and over who have a diagnosis of respiratory disease, diabetes and heart failure and meet the acceptance criteria. Patients must reside within Stoke-on-Trent or North Staffordshire CCGs.

3.4 Any Acceptance and Exclusion Criteria and Thresholds

Referral Criteria for the Integrated Specialist Long Term Conditions Service

Patients being referred should meet the following criterion:

- Confirmed diagnosis, or high suspicion of diabetes, respiratory disease and/or heart failure.

Please refer to **Appendix B** for a detailed referral criteria for the Community Diabetes Team.

4.17.2 Exclusion Criteria

- Those with a diagnosis other than diabetes, respiratory disease and/or heart failure.
- Those under 18 years of age.
- Those not registered with a GP within Stoke-on-Trent or North Staffordshire CCG's.
- Pregnant women with Diabetes.

3.5 Interdependence with other services/providers

- GPs and Practice Nurses
- Other healthcare professionals i.e. dieticians, podiatrists
- Community Matrons
- District nurses
- Acute Consultants
- Specialist Nurses in secondary care
- Ward Based staff
- Developing MCPs and care hubs
- Intermediate Care Teams
- Care Home staff
- Voluntary sector and peer support services
- Palliative Care teams
- Service Integrator for End of Life Care
- Disability Solutions (PHB Brokerage)

4. Applicable Service Standards

4.1	Applicable national standards (eg NICE)
	- NICE Guidance relating to Respiratory Diseases, Diabetes and Heart Failure - NSF for Long Term Conditions – Department of Health (2005) - NICE Quality Standards relating to Respiratory Diseases, Diabetes and Heart Failure
4.2	Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)
4.3	Applicable local standards
	Local Health Economy-wide Joint Medicines Formulary
5.	Applicable quality requirements and CQUIN goals
5.9	Applicable Quality Requirements (See Schedule 4 Parts [A-C])
5.2	Applicable CQUIN goals (See Schedule 4 Part [C])
6.	Location of Provider Premises
	The Provider's Premises are located at: Various locations around Stoke-on-Trent and North Staffordshire.
7.	Individual Service User Placement
	Not Applicable.

Service specification number	CS_32
Service	Community Heart Failure Service, Stafford and Surrounds and Cannock Chase
Service Commissioner Lead	Simon Runnett
Provider Lead	Steve Foster / Adam McKeown
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.1 National Context and Evidence Base

Chronic heart failure is a complex clinical syndrome of symptoms and signs that suggest the efficiency of the heart as a pump is impaired. It is caused by structural or functional abnormalities of the heart. Some individuals have chronic heart failure due to left ventricular systolic dysfunction (LVSD), which is associated with a reduced left ventricular ejection fraction. Most of the evidence on treatment is for chronic heart failure due to LVSD. The most common cause of chronic heart failure in the UK is coronary artery disease, and many people with chronic heart failure have had a myocardial infarction in the past.

Around 900,000 people in the UK have chronic heart failure. Almost as many have damaged hearts but have no symptoms of heart failure. Both the incidence and prevalence of heart failure increase steeply with age, with the average age at first diagnosis being 76 years. The prevalence of heart failure is expected to rise in the future as a result of an ageing population, improved survival of people with ischaemic heart disease and more effective treatments for heart failure.

People with chronic heart failure often experience a poor quality of life; symptoms include breathlessness, fatigue and ankle swelling, and over one third of people with chronic heart failure experience severe and prolonged depressive illness. Chronic heart failure has a poor prognosis: 30–40% of people diagnosed with chronic heart failure die within 1 year; thereafter the mortality is less than 10% per year.

Chronic heart failure accounts for 2% of all NHS inpatient bed-days and 5% of all emergency medical admissions to hospital. Readmissions are common: about one in four people with chronic heart failure are readmitted within 3 months. [NICE support for commissioners and others using the quality standard for chronic heart failure](#) indicates that although there may be cost implications in implementing NICE guidance to meet the quality standard for chronic heart failure, there is potential for overall savings as a result of reduced hospital admissions.

The [NICE clinical guideline 108](#) on chronic heart failure recommends that heart failure care should be delivered by a multidisciplinary team with an integrated approach across the healthcare community. Effective multidisciplinary specialist services for people with chronic heart failure can have a positive effect on a person's life expectancy and quality of life, and evidence suggests they can help to reduce recurrent hospital stays by 30–50%. The service provides specialist nurses with access to primary care practitioners and secondary care consultants.

Prevalence of heart failure in South Staffordshire is outlined in the table below. It is also recognised that heart failure is under-diagnosed in primary care.

Local Prevalence (QOF 2015/16)

Organisation	Practice list size	Heart Failure: QOF prevalence Percentage
Stafford & Surrounds	146,911	0.77%
Cannock Chase	131,790	0.92%
South East Staffs & Seisdon	216,951	0.79%
England		0.76%

Specialist nurse programmes for people with heart failure have been shown to be effective in assessing individual needs, optimising care by improving the uptake of pharmacological treatments, reduce recurrent hospital stay by 30-50% and appear to be most effective in high risk patients.

2. Outcomes

2.1 NHS Outcomes Framework Domains and 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	

2.2 Expected Outcomes

- Reduction in emergency hospital admissions
- Reduction in length of stay
- Improved quality of life for heart failure patients
- Increased self-management
- Increased number on appropriate therapy/titration
- Increased skills in community nursing, practice nursing and general practice
- Increasing the number of people with personalised care plans to support and increase confidence to self-manage
- Aim to facilitate a seamless pathway across primary, community and secondary care

Aims and objectives of the service

To deliver a specialist community heart failure nursing service, which shall:

- provide individualised programmes of care for patients which promote self-management
- facilitate evidence based management of heart failure patients within community and primary care settings
- optimise patient outcomes including quality of life
- promote seamless transfer of care between settings
- reduce unplanned utilisation of secondary care

Objectives

- Improve the management of patients with a diagnosis of heart failure through education
- Reduce admissions and readmissions to hospital through intervention and education
- Reduce patient's length of stay in hospital.
- Improve quality of prescribing, dose titration and concordance with medication
- Increase the use of evidence based therapies and medications
- Increased appropriate management of heart failure across Cannock Chase and Stafford and Surrounds through increasing both confidence and competence in primary/community care staff through their upskilling via education and support Increase quality of life for heart failure patients
- Promote self-care behaviour for heart failure patients, empowering patients to self-manage their condition
- Empower patients and their carers to make informed choices through knowledge and education
- Ensure equity of access to heart failure services.
- Provide education and support for primary and community healthcare professionals to develop a more skilled workforce – the Heart Failure team will promote awareness of the service to a range of healthcare professionals including GPs, Practice Nurses and Healthcare Assistants
- Improve links between healthcare professionals to promote seamless transfer to care between settings

Service description / care pathway



The Heart Failure Service in Stafford and Surrounds and Cannock Chase is a community based service designed for patients with diagnosed Left Ventricular Systolic Dysfunction (LVSD). It delivers the priorities in accordance with NICE guidelines (2010).

The service will provide direct clinical interventions to patients to optimise management of heart failure through assessment, optimising therapy, patient support, management and education via community clinics, home visits and telephone consultations. GP practices will generally initiate the initial diagnostic blood test, with ongoing tests to be performed/requested by the Heart Failure team. The Heart Failure team will also conduct ECGs on patients currently active on their caseload (with secondary care being responsible for chest X-rays and Echocardiogram).

The service will facilitate a holistic approach to patient care by liaising between primary, community and secondary care to ensure delivery of seamless patient-centred care. This involves facilitating onward referrals to appropriate services and working closely with other healthcare professionals who are involved in the care of a patient. The service will co-ordinate onwards referrals internally to other services, where appropriate eg District Nursing, Dietetics.

Patients are provided at the first visit with a written individualised self-management plan with clear guidance on how to seek help and support from the team along with the team telephone numbers and this is reinforced at each patient contact. Patients are also provided with the 'living with heart failure' booklet provided by the British Heart Foundation. This encompasses information about claiming benefits, travel, vaccinations, smoking, healthy life styles and self-management.

Clinical Leadership and medical governance specific to Heart Failure will be provided by Consultant Cardiologists via weekly multi-disciplinary team (MDT) meetings and provision of supervision and advice to the specialist nurses. Nursing Leadership will be provided by the SSOTP Professional Head of Nursing. Heart Failure Nurses can take forward patients to this MDT and will communicate back to GPs where it is appropriate to do so. Heart Failure Nurses should also link in closely to GP-led MDTs across Stafford and Surrounds and Cannock Chase.

The Heart Failure Nurse Specialist will both prescribe and advise on the titration and optimisation of ACE Inhibitors and Beta Blockers. Blood tests will be performed and reviewed in a timely manner by the Heart Failure Nurse during the titration schedule and ongoing adjustments made in accordance with the changing clinical status of an individual patient. Other heart rate lowering drugs will be down titrated as appropriate to ensure patients receive the full prognostic benefits of Beta Blocker therapies. Loop diuretics will be adjusted in accordance with clinical symptoms and fluid status and Mineralcorticoid Receptor Antagonists and thiazide diuretics will be considered where appropriate for on going management.

The Heart Failure Nurse Specialist will also review the need for other specialist heart failure medication such as Ivabradine and Sacubitril/Valsartan on an individual clinical need basis following discussion with senior colleagues within cardiology MDT's and recommendations in accordance with NICE Guidance 108.

The service will provide:

- Examination and assessment
- Medication review
- Initiation, titration and optimisation of heart failure medication - the community heart failure nurses have the skills, knowledge, autonomy and expertise to titrate and optimise medication in line with the NICE guidelines. Other primary care colleagues utilise our specialist skills on a daily basis.
- Advice and support on lifestyle
- Patient education and empowerment - information, education and support for people with chronic heart failure and the promotion of self-management
- Response to exacerbations and offer case management support for complex cases
- Working in partnership with palliative care services and voluntary sector where appropriate for palliative phase
- Development and agreement of a management plan with clear follow up arrangements
- The monitoring of active patients on their caseloads as per NICE guidance. GP's will then accept responsibility for on-going management as per discharge letter to GP from the team.
- The opportunity for patients to self-refer back into the service (rather than be re-referred back in via their GP).
- Engagement with GP re DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) orders.

The service will be delivered in line with the acceptance and exclusions criteria and service requirements outlined in this specification in accordance with current NICE guidance (2010).

Stafford and Cannock Heart Failure team do not provide cardiac rehabilitation, if appropriate a referral can be made to the cardiac rehab services within secondary care.

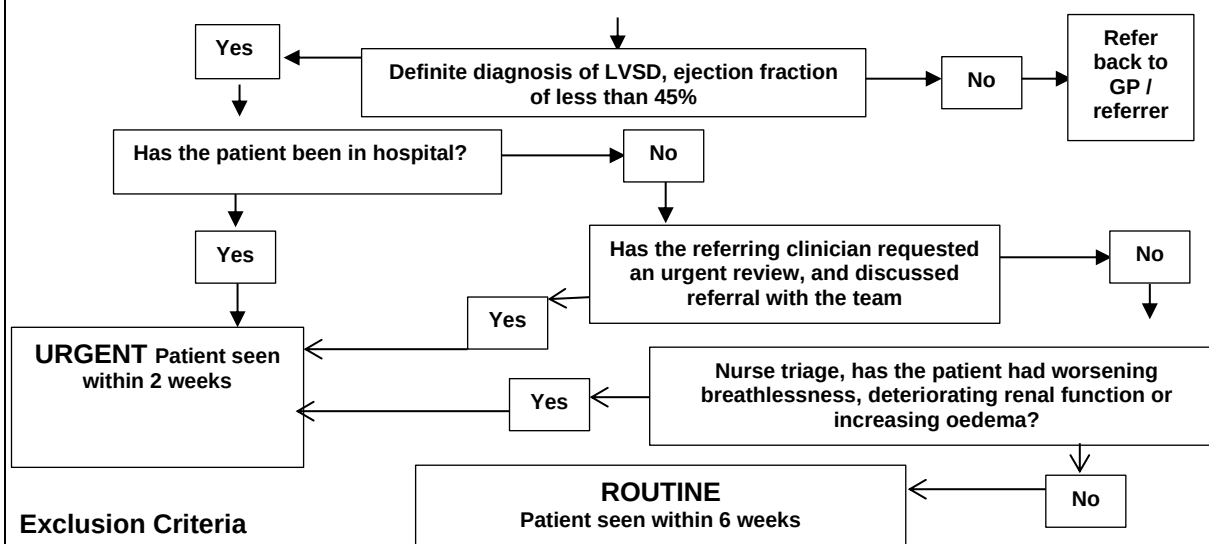
Population covered

All adults aged 18 and over with diagnosis of LVSD. Patients must be registered with a GP in Stafford and Surrounds / Cannock Chase.

Any acceptance and exclusion criteria and thresholds

Referral criteria

- Patients with confirmed diagnosis of LVSD (Left Ventricular Systolic Dysfunction) with an ejection fraction of 45% or less.
- Patients registered with a GP in Stafford and Surrounds / Cannock Chase
- Referrals accepted from any healthcare professional providing appropriate diagnosis confirmed by Echocardiogram or other imaging



Exclusion Criteria

- Patients with an ejection fraction greater than 45%

Interdependence with other services / providers

To ensure a patients experience is a streamlined journey and a good experience the provider must work collaboratively with the commissioner, primary care and secondary care providers to deliver services in an organised and cohesive manner. Where appropriate the provider must develop effective links with other statutory providers and voluntary sector organisations.

The service shall ensure that it actively works with acute and community teams to step patients up or down ensuring efficiency and throughput.

3. Applicable Service Standards

3.1 Applicable National Standards (eg NICE)

NICE guidance for Chronic Heart Failure (2010)

<http://www.nice.org.uk/nicemedia/live/13099/50517/50517.pdf>

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

Not Applicable

3.3 Applicable local standards

Cannock and Stafford and Surrounds Operational Guidelines for the Nurse Led Heart Failure Service

4. Applicable quality requirements and CQUIN goals

4.1 Applicable quality requirements (see schedule 4 parts A-C)

4.2 Applicable CQUIN goals (See schedule 4 Part D)

Not applicable

5. Location of Provider Premises

The Provider premises are located at:

Weeping Cross Health Centre, Bodmin Avenue, Stafford ST17 0EG

6. Individual Service User Placement

Not applicable

Service Specification No.	CS_33
Service	Community step up IV antibiotics service
Commissioner Lead	Gina Gill
Provider Lead	Adam McKeown
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

Home intravenous antibiotic programmes have been highlighted by the Department of Health as having a high potential for care provision in a community setting.

There have been many reviews published which indicate that administering the initial doses of IV therapy in a non-hospital environment is safe. Patients are more satisfied by home treatment and this improves quality of life. A nurse led home IV antibiotics service that delivers therapy in patients' usual place of residence will improve the patient experience, deliver care in a more convenient and appropriate setting and enable cost savings through preventing hospital admission. It is important however when developing a service to ensure that is patient-focused and safe, minimising the risks associated with treating patients with severe infections out of hospital.

Some examples of reviews published are:

- Smego (2009) found that both UK and international qualitative studies demonstrate that IV therapy can be delivered safely and effectively in patients' own home (Smego, 2005; Esposito, 2000; Tice, 1995).
- Lomas C (2009) wrote in the Nursing Times about a nurse-led community IV therapy service run by nurses in Warrington, enabling nurses to administer IV therapy to patients within their home. Of the 751 patients treated only 27 had to be admitted to hospital (just 3.6% of the total number of patients referred). This resulted in over 7,000 bed days saved. cost of around £2,353 per patient for IV therapy treatment in hospital. The trust saved almost £1,500 per patient.
- Wolter et al (2004) conducted a randomised controlled trial (RCT) of home versus hospital IV antibiotic therapy in Australia. Their study included 129 patients who were referred for IV therapy. It is unclear how long the whole trial lasted but the authors drew several positive conclusions. The issue of safety was mentioned. There was evidence to indicate that antibiotic therapy given intravenously in the home carries no greater risk than when administered in hospital.
- Balinsky and Mollin (1998) undertook a literature review on home drug infusion therapy, which concentrated on cost-effectiveness studies of parenteral antibiotic therapy administered in an outpatient setting. They noted that home healthcare typically appeals to quality-of-life arguments, and that most people prefer to recuperate in their own beds.
- Kayley (1996), an English nurse specialist, published one of the earliest reviews of the subject in Britain. Her then health authority developed an outpatient IV antibiotic therapy programme that evolved from the desire to provide high-quality IV therapy to patients with Aids. This programme capitalised on the strengths of the community nurse system and minimised the need for extra resources.
- Nathwani and Morrison (2001) reviewed the evidence and evaluated future prospects for IV therapy at home. They acknowledged studies by Esposito (2000) and Wilson et al (1999) and noted that considerable savings in hospital costs can be made, as well as reducing the risk of contracting a healthcare-associated infection

- Wilson et al (1999) conducted what they claim was the first RCT directly to evaluate a hospital avoidance scheme. The eight-month trial randomised 199 consecutive patients to either hospital or hospital-at-home treatment. Six per cent of patients randomised to the hospital-at-home group refused to be admitted to it. However, of greater importance is the fact that 24% of those randomised to the hospital group refused as they preferred to be treated at home. This provides strong evidence that many patients prefer home to hospital treatment.

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

- The patient and/ or representative shall feel involved in all aspects of their care planning.
- The patient and/ or representative shall feel empowered to make decisions and choices about all aspects of their life, condition, care and services accessed.
- The patient and/ or representative shall feel that they are at all times treated with dignity and respect.
- Enhanced patient and carer experience, independence, satisfaction with the service received and quality of life.

3. Scope

3.1 Aims and objectives of service

3.2 The aims and objective of the service is to deliver a safe and effective community based IV antibiotic service in order to reduce hospital admissions by managing patients who require intravenous therapy for non-complex condition in their own home.

3.3 The overarching aims and objectives are to;

- Enhance the patient pathway by effectively managing patients within the community
- Provide fast, timely access to assessment, treatment and care

3.4 Service Description

3.5 The service will be nurse led with prescribing responsibilities covered by ANPs. The service will provide information, support and advice to ensure patients are managed effectively and safely and will retain clinical responsibility for these patients until the point of discharge.

3.6 The service shall:

- Provide an effective triage service to ensure only patients suitable for home therapy are treated at their usual place of residence. Patients requiring treatment in an acute setting will be referred to the appropriate team via existing pathways.
- Use an appropriate decision making tool to prescribe appropriately (oral or IV).
- Provide a clinically effective, quality Home IV Antibiotics service from treatment initiation to discharge for patients who do not need to be treated in hospital.

- Be able to prescribe and make changes to patient prescriptions when required.
- Be able to effectively treat any reaction to the administration of medication including resuscitation measures such as airway management, and administration of an appropriate adrenaline drug
- Provide an even distribution of competency across the local health economy, covering all localities as required.

3.7 The Home IV Therapy Service will cover a range of treatments for the following conditions :

- Uncomplicated or stable Chest Infections* to be developed in collaboration with commissioners
- Uncomplicated Cellulitis
- Uncomplicated UTIs

3.8 Care Pathway

3.9 Referral to the service is via the agreed referral from a GPs and healthcare professionals.

3.10 Referrals will be triaged for suitability within 1 hour and assessed with within 2 hours for urgent referrals and 4 hours for non-urgent referrals upon receipt of request. Once the referral is deemed appropriate, an initial assessment will be offered to the patient on the same day. Treatment to be initiated in line with agreed care pathway and medicines management protocols.

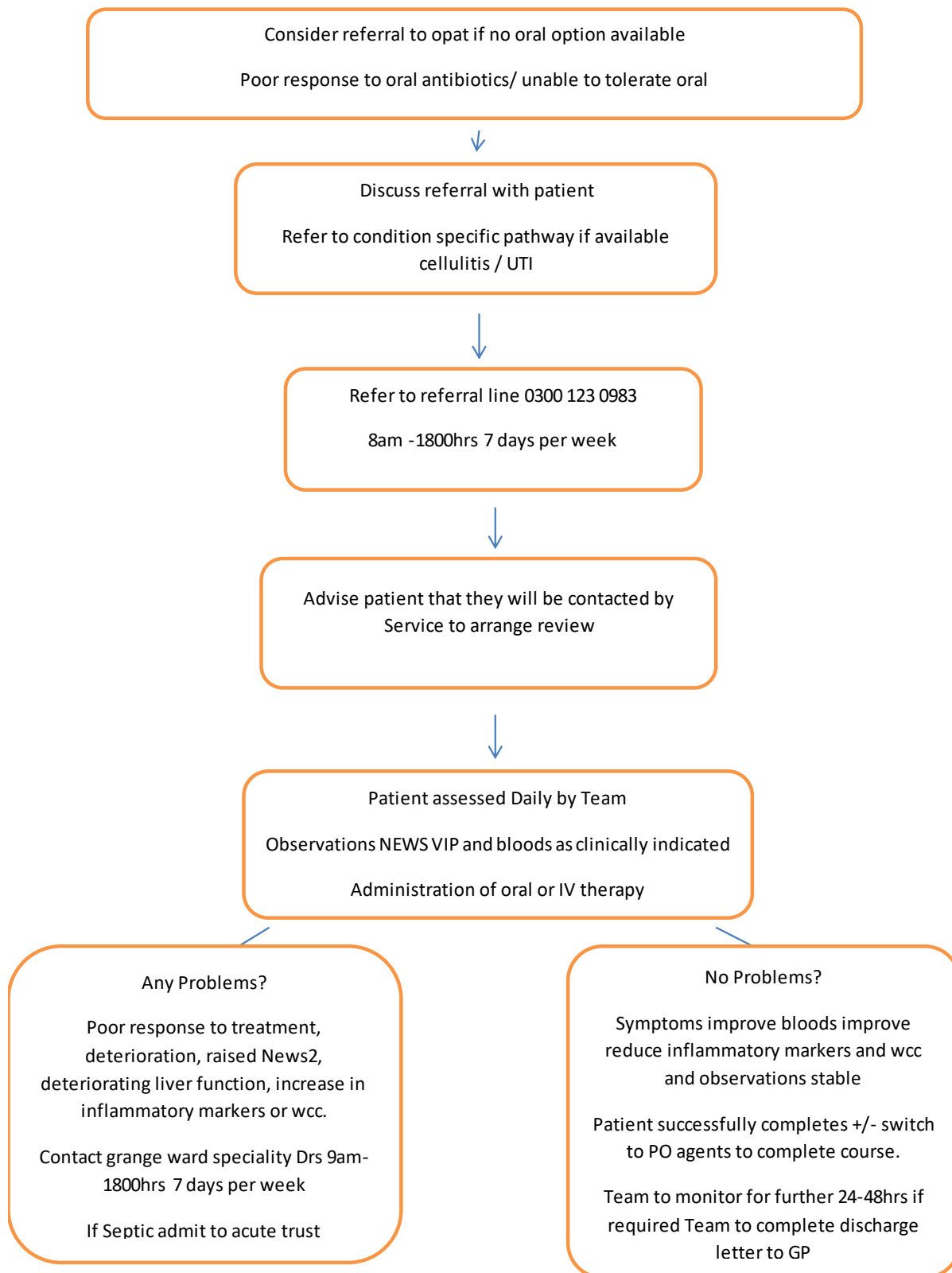
3.11 Patients who fall into the exclusion criteria will be promptly referred onto a clinically appropriate service for further investigation

3.12 The service shall ensure that all patients have a self-care plan on discharge and that relevant advice and literature is given to the patient and/or carer

3.13 Upon discharge from the service, the provider shall ensure a discharge report is shared with the patients GP

3.14 Referral Pathway

OPAT Step up referral pathway



3.15 Population Covered

3.16 The service shall provide care to any patient aged 18 and over that is registered with a North Staffordshire or Stoke-on-Trent General Practitioner (GP).

3.17 Location (s) of Service Delivery

3.18 The service shall be delivered from the patient's usual place of residence.

3.19 Hours of Operation

The service shall be offered 7 days a week, 52 weeks a year 9am – 8pm (however this may be revised in line with operational developments and in response to the needs of patients).

3.20 Inclusion Criteria

- Patients aged 18 and over
- Patients registered to a North Staffordshire or Stoke on Trent CCG
- Patients requiring IV antibiotics for uncomplicated conditions clearly defined in the providers referral criteria and compliant with agreed clinical pathways
- Patients must be haemodynamically stable

3.21 Exclusion Criteria

- Children under the age of 18
- Patients not registered to a North Staffordshire or Stoke on Trent CCG
- Patients who are pregnant and/or breastfeeding
- Immunocompromised patients (unless explicit approval to treat given by microbiology)
- Patients unable to tolerate outpatient parenteral antimicrobial therapy

3.22 Interdependencies with other services

3.23 The Provider will use their specialist expertise to creatively develop safe and effective ways to deliver positive outcomes in collaboration with partners and by building on existing good practice and positive relationships.

3.24 Ensure access for the patient to all relevant services as may be required in accordance with individual needs as below, but not limited to:

- Allied Health Professions
- Primary Care/General Practitioners
- Acute and Community Hospitals
- Other Community Services e.g. Infection & Prevention Team, Tissue Viability Team, Continence Team

3.25 Workforce

3.26 All staff providing the service must provide evidence to demonstrate their respective experience and competencies required. Annual audits are required to ensure compliance.

3.27 The Service shall be responsible for ensuring that (where relevant) their clinical and / or non-clinical staff:

- Are up to date with all statutory mandatory training;
- Have relevant professional registration and enhanced Criminal Record and Barring checks undertaken prior to seeing patients alone
- Have maintained relevant professional registration whilst delivering services on behalf of the Provider. The Provider is required to conduct frequent registration audits to ensure compliance

3.28 The service shall be staffed by appropriately qualified health care professionals in sufficient numbers to deliver the needs of the service. All staff should meet the required clinical accreditation standards and competencies for delivery.

3.29 Governance

3.30 The service provider will take on full governance responsibility for patients treated with IV antibiotics in their home. They will ensure that appropriate and adequate medical governance is in place to support the safe and effective delivery of the service. This will include;

- Assessment and Triage
- Prescribing and treatment initiation
- Changes to medication prescriptions during treatment
- Ongoing provision of IV antibiotics therapy in the patients homes
- Adherence to medicines management protocols for the duration of the treatment for all drugs and prescribing

4. Applicable Service Standards

4.1 Applicable national standards (i.e. NICE)

- NHS Institute for Innovation and Improvement, Seven Ways to No Delays, 2010
- National Commissioning Board, Everyone Counts: Planning for Patients, (2013-2014)
- National Commissioning Board, The CCG Outcomes Indicator Set, (2013-2014)
- Department of Health. Care Closer to Home / Our Health Our Future review -Lord Darzi report (DH 2007)
- Care Act (2014)
- NICE guideline [NG111] Pyelonephritis (acute): antimicrobial prescribing. October 2018
<https://www.nice.org.uk/guidance/ng111>
- NICE guideline [NG109] Urinary tract infection (lower): antimicrobial prescribing October 2018
<https://www.nice.org.uk/guidance/ng109>
- NICE guideline [NG112] Urinary tract infection (recurrent): antimicrobial prescribing October 2018
<https://www.nice.org.uk/guidance/ng112>
- NICE guideline [NG11] Urinary tract infection (catheter-associated): antimicrobial prescribing November 2018 <https://www.nice.org.uk/guidance/ng113>
- Clinical knowledge summary : Acute Cellulitis April 2016 <https://cks.nice.org.uk/cellulitis-acute#!scenario>

4.2 Relevant Legislation

4.3 The Provider shall meet and maintain national quality standards and any other national quality requirements that may from time to time be specified; and shall comply with all relevant legislation, national policy and national guidance including those detailed within the following non-exhaustive list as may exist or come into effect from time to time:

- Essential Standards for Quality and Safety (2010)
- Dignity in Care (2010)
- Equality Act (Oct 2010)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 2012
- Care Closer to Home (2006)

5. Applicable quality requirements and CQUIN goals

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

5.1 Applicable CQUIN goals (See Schedule 4 Part D)

6. Location of Provider Premises

The provider will delivery the service at the service users' home or place of residence.

Service Specification No.	CS_40
Service	Fracture Liaison Service (North Staffordshire & Stoke-on-Trent)
Commissioner Lead	Becky Scullion
Provider Lead	Dr Zoe Paskins, Clinical Lecturer and Honorary Consultant in Rheumatology
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.1 National Context

Over three million people in the UK have osteoporosis; these people are at a substantially increased risk of fragility fractures.ⁱ Every year hip fractures alone in the UK account for 1.8 million hospital bed days and £1.9 billion in hospital costs, excluding the high cost of social care.^{ii iii} Preventing fragility fractures and the resulting hospital admissions is clinically and economically effective and will result in substantial cost savings for the health and social care services.

1.2 Evidence Base

The best way to reduce the number of fragility fractures suffered by older people is through the development of local Fracture Liaison Services (FLS). FLSs systematically identify, treat and refer to appropriate services all eligible patients over 50 who have suffered fragility fractures, with the aim of reducing their risk of subsequent fractures.

Most primary care organisations do not have access to services for secondary fracture prevention; currently only 42% of health economies in the UK offer some form of FLS.^{iv} Prevention of a secondary fracture improves quality of life, as well as reducing health and social care costs and hospital admissions. Therefore FLS is an important tool that should be developed as part of a hospital's admission avoidance strategy. Current national guidance provides evidence that effective case finding and use of appropriate drug therapies will reduce the risk of future clinical fracture by up to 50% and these reductions in fracture incidence are realised quickly and certainly within three years of pharmacotherapy.

There is a strong published evidence base for the effectiveness of FLS contained in the following publications:-

- Department of Health, 2009. Falls and Fractures: Effective interventions in health and social care.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digital_assets/@dh/@en/@pg/documents/digitalasset/dh_109122.pdf
- Department of Health, 2009. Fracture Prevention Services: An economic evaluation.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digital_assets/documents/digitalasset/dh_110099.pdf
- British Orthopaedic Association, 2007. The Blue Book: The Care of Patients with Fragility Fractures.
<http://www.fractures.com/pdf/BOA-BGS-Blue-Book.pdf>
- Royal College of Physicians, 2007. National Clinical Audit of Falls and Bone Health for Older People.
<https://www.rcplondon.ac.uk/sites/default/files/national-clinical-audit-of-falls-and-bone-health-in-older-people-national-report-2007.pdf>
- National Osteoporosis Society, 2012. Breaking Through: Building Better Falls and Fracture Services in England.
<http://www.nos.org.uk/document.doc?id=987>

1.3 General Overview

The British Orthopaedic Association has stated that "A major change is needed in fracture services to ensure that every patient presenting with a fragility fracture is assessed for osteoporosis and referred for treatment as appropriate. Secondary prevention should not only address osteoporosis but the risk of additional falls should be addressed, in terms of the patient's medical condition and that of their environment."^v

Research has shown that a previous fracture increases a patient's risk of suffering a further fracture by at least twice and that this risk of further fractures may be even greater in men. The future fracture risk is greatest during the first year following the initial fracture. This highlights the need for early and structured post fracture interventions. It has also been shown that

increased emphasis on prevention strategies, such as pharmacotherapy, reduces the incidence of re-fracture between 20 and 70% depending on the fracture site. The reduction in fracture incidents is realised during three years of pharmacotherapy.

Approximately 50% of hip fracture patients have experienced a prior fragility fracture; this could have served as a trigger for assessments of both osteoporosis and falls risk thereby reducing the risk of a secondary fracture occurring.^{vi} Fractures should not be thought of as isolated events but rather as part of an ongoing chronic disease process ultimately associated with progressive morbidity and premature mortality.

Early assessment aimed at prevention of secondary fragility fractures will result in optimisation of clinical care, which will lead to improved outcomes in terms of:

- Long term reduction in fragility fracture risks
- Decrease in delay in assessments for bone health
- Appropriate referral for bone densitometry via DXA
- Medication adherence through education and support
- Improved quality of life
- Improved health & well-being
- Referral into and uptake of falls services to implement interventions around falls
- Reduction in mortality rate

A systematic approach to the prevention of secondary fractures is advocated in evidence-based best practice as the most effective treatment strategy for patients at risk. The second of the Department of Health's four objectives in its systematic approach to falls and fracture care and prevention is '*Respond to the first fracture, prevent the second*'^{vii}.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

This section sets out the indicators in each of the outcomes frameworks to which a fracture liaison service will contribute to the achievement.

NHS Outcomes Framework 2014 – 2015

DOMAIN 3: Helping people to recover from episodes of ill health or following injury - Improving recovery from fragility fractures
3.5 *Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days*

CCG Outcomes Indicator Set 2014 – 2015

DOMAIN 1: Preventing people from dying prematurely -Reducing premature death from fragility fractures – Hip fracture incidence

1.22 *The rate of people admitted with a primary diagnosis of hip fracture per 100,000 CCG population*

DOMAIN 3: Helping people to recover from episodes of ill health or following injury - Improving recovery from fragility fractures
Improving recovery from fragility fractures – Hip fracture: formal hip fracture programme

3.11 *Of people with hip fracture, the proportion who receive a formal Hip Fracture Programme from admission evidenced as having a joint acute care protocol at admission, and evidence of multidisciplinary team (MDT) rehabilitation agreed with a responsible orthogeriatrician and orthopaedic surgeon, with General Medical Council (GMC) numbers recorded*

Improving recovery from fragility fractures – Hip fracture: timely surgery

3.12 *Of people with hip fracture, the proportion who receive surgery on the day of, or the day after, admission*

Improving recovery from fragility fractures – Hip fracture: multifactorial risk assessment

3.13 *Of people with hip fracture, the proportion who receive a multifactorial risk assessment of future falls risk, led by the Hip Fracture programme team evidenced by GMC number of responsible clinician*

Public Health Outcomes Framework 2013 – 2016

DOMAIN 2: Health Improvement

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities - Injuries due to falls in people aged 65 and over

2.24i *Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population. [2.24ii and 2.24iii break this down into age groups 65-79 and 80+]*

2.2 Locally defined outcomes

Service outcomes

The service will deliver a number of outcomes, some of which are measureable and are suitable for conversion into performance indicators, these are:

Type	Outcome	Suggested performance indicator

Clinical	Increase in number of patients receiving structured follow up	Number of patients followed up by telephone at a) 3 months and at b) 12 months as a percentage of total number of patients for whom follow up is appropriate
Clinical	Improved adherence to prescribed medication leading to reduced risk of fracture	Number of patients compliant with prescribed medication as a percentage of those initiated at, a) 3 months and at, b) 12 months
Clinical	Increase in number of patients receiving assessment / treatment	Number of patients completing patient pathway (excluding follow up) as a percentage of total number of patients identified as eligible
Patient experience	Increase in number of patients satisfied or highly satisfied with the service	Number of patients stating that they are 'satisfied' or 'highly satisfied' as a percentage of total number in sample
Patient experience	Reduction in average wait time regardless of CCG practice of registration	Average waiting time in reporting period between date of fracture and assessment appointment completed
Patient experience	Compliance with maximum waiting time regardless of CCG practice of registration	Number of patients seen within 8 weeks of fracture
Finance / activity	Reduction in number of FLS appointments charged at rheumatology tariff	Average waiting time in reporting period

The service will maintain a comprehensive database which will capture information about all patients and support the timely reporting outcomes and performance indicators.

The service will also participate in the national FLS database project being run by the National Osteoporosis Society and audit against international standards (Capture the Fracture). This will be an additional source of benchmarked performance information in due course.

Health economy outcomes

There are a number of outcomes that would be expected based on available evidence but which are not amenable to measurement by the SSOTP FLS, these are:

Type	Outcome	Suggested performance indicator
Finance / activity	Reduction in number of fragility fractures admitted to hospital adjusted for demographic change	None
Finance / activity	Reduction in number of fragility fractures not admitted to hospital adjusted for demographic change	None

3. Scope

3.1 Aims and objectives of service

The development of an FLS presents an opportunity to break the fragility fracture cycle through the overall aim of responding to the first fracture and preventing the second.

The objectives of the service are to:

- To ensure that patients who sustain a fragility fracture receive secondary bone health assessments and interventions
- To ensure that patients receive appropriate follow up care following a fracture in order to obtain optimum benefit from the treatment
- Deliver best practice in a cost effective way through a locally agreed pathway
- Improve the quality of the experience for the individual and their family through delivery of service to best practice standards and maintenance of acceptable waiting times
- Reduce the cost to the health economy of fragility fractures through effective prevention of secondary fractures
- Reduce costs to North Staffordshire CCG of FLS appointments charged at rheumatology tariff

3.2 Service description/care pathway

A separate care pathway has been published to accompany this service specification. The service will include:

- Case finding in fracture clinic, emergency department, inpatient wards and outpatient clinics including weekly search of radiology images database
- A one-stop clinic service providing treatment to national guidelines for falls and bone health, located within the Osteoporosis service at the Haywood hospital
- Diagnosis of osteoporosis using DXA
- Identification of patients whose behaviour can be modified and referral to a falls prevention service
- Recommendation of treatment and follow up plan to GP
- Telephone follow up of patients at 3 months and 12 months carried out to agreed protocol
- Additional appointments for patients requiring change in medication or other treatment / support
- Education and support for primary care
- Specialist support from secondary care clinicians in managing complex and rare bone conditions

- Case finding in fracture clinic, emergency department, inpatient wards and outpatient clinics including weekly search of radiology images database – planned as a service development during year 1 of service delivery

Service Delivery

- The service shall operate Monday – Friday, 8am – 4pm
- During operating hours the service shall respond to FLS telephone messages within 1 working day

3.3 Population covered

The service will assess and manage the bone health of all patients over 50 who have suffered a fragility fracture to prevent subsequent fractures.

The service will be available to:

- All patients admitted to University Hospitals of North Midlands NHS Trust
- All patients registered with a GP practice in North Staffordshire CCG; NHS Stoke-on-Trent CCG and other CCGs where commissioned

3.4 Any acceptance and exclusion criteria and thresholds

The service will accept and manage the assessment of osteoporosis and future fracture risk of all patients over 50 who have suffered a fragility fracture to prevent subsequent fractures.

Referrals are accepted from:

- Medical Assessment Unit
- Fracture Clinic
- Medical and care of older people wards
- Emergency department
- GPs
- Community nurses
- Community hospital
- Physiotherapists
- Other AHPs

Referral Route

Referrals to the FLS service at the Haywood hospital may be made through the following channels:

- Letter
- Telephone 01782 673897
- Fax 01782 673897DXA referrals, which are triaged to FLS if patient has had a recent fracture
- Electronic mail or message [to be confirmed]

Exclusion criteria

The following categories of patient will be excluded from access to the service:

- No evidence of fragility fracture
- Fracture due to high trauma or metastasis or other bone pathology
- Female inpatients over 75 years of age and male inpatients over 90 years of age with hip fractures are managed by the ortho-geriatric team and would not normally be referred into the FLS service.

3.5 Interdependence with other services/providers

The service shall operate as part of an integrated system for the prevention of fractures and falls. It will, therefore, work closely with other parts of the health and social care system including:

- Medical assessment unit
- Orthopaedics and trauma
- Rheumatology
- Medicine and care of older people departments

- Emergency department
- Radiology
- Intermediate Care
- Falls co-ordinator and falls prevention services
- GPs
- Community nurses
- Community hospitals
- Clinical commissioning groups
- Physiotherapists
- Other AHPs

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE Technology appraisal TA160, [Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women](#), 2008 (amended 2011); National Institute for Care and Health Excellence
- NICE Technology appraisal TA161, [Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for preventing bone fractures in postmenopausal women with osteoporosis who have already had a fracture](#), 2008 (amended 2008); National Institute for Care and Health Excellence
- NICE Clinical guideline CG146, [Osteoporosis: assessing the risk of fragility fracture](#), 2012; National Institute for Care and Health Excellence
- NICE Clinical guideline TA204, [Denosumab for the prevention of osteoporotic fractures in postmenopausal women](#), 2010; National Institute for Care and Health Excellence
- Sign Guidance: [Management of Osteoporosis. Guideline No 71](#). 2004.

4.2 Applicable standards set out in Guidance and/or issued by a competent body

- National Osteoporosis Society Standards for fracture liaison services. <https://www.nos.org.uk/page.aspx?pid=1816>
- National Osteoporosis Society, 2012. Breaking Through: Building Better Falls and Fracture Services in England. London: National Osteoporosis Society. Available at: <http://www.nos.org.uk/document.doc?id=987>
- Royal College Physicians recommends that commissioners use the Department of Health prevention package to inform the commissioning of effective falls and fracture services. See Objective 2 in *Falls and Fractures: Effective interventions in health and social care* at http://www.laterlifetraining.co.uk/wp-content/uploads/2011/12/FF_Effective-Interventions-in-health-and-social-care.pdf
- International Osteoporosis Foundation, Capture the Fracture – global campaign to break the fragility fracture cycle at <http://www.iofbonehealth.org/capture-fracture>
- British Orthopaedic Association, 2007. The Blue Book: The Care of Patients with Fragility Fractures. <http://www.fractures.com/pdf/BOA-BGS-Blue-Book.pdf>
 - Blue Book Standard 5 - All patients presenting with fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future fractures
 - Blue Book Standard 6 - All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.

4.3 Applicable local standards

Patients seen within 8 weeks of fracture diagnosis

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

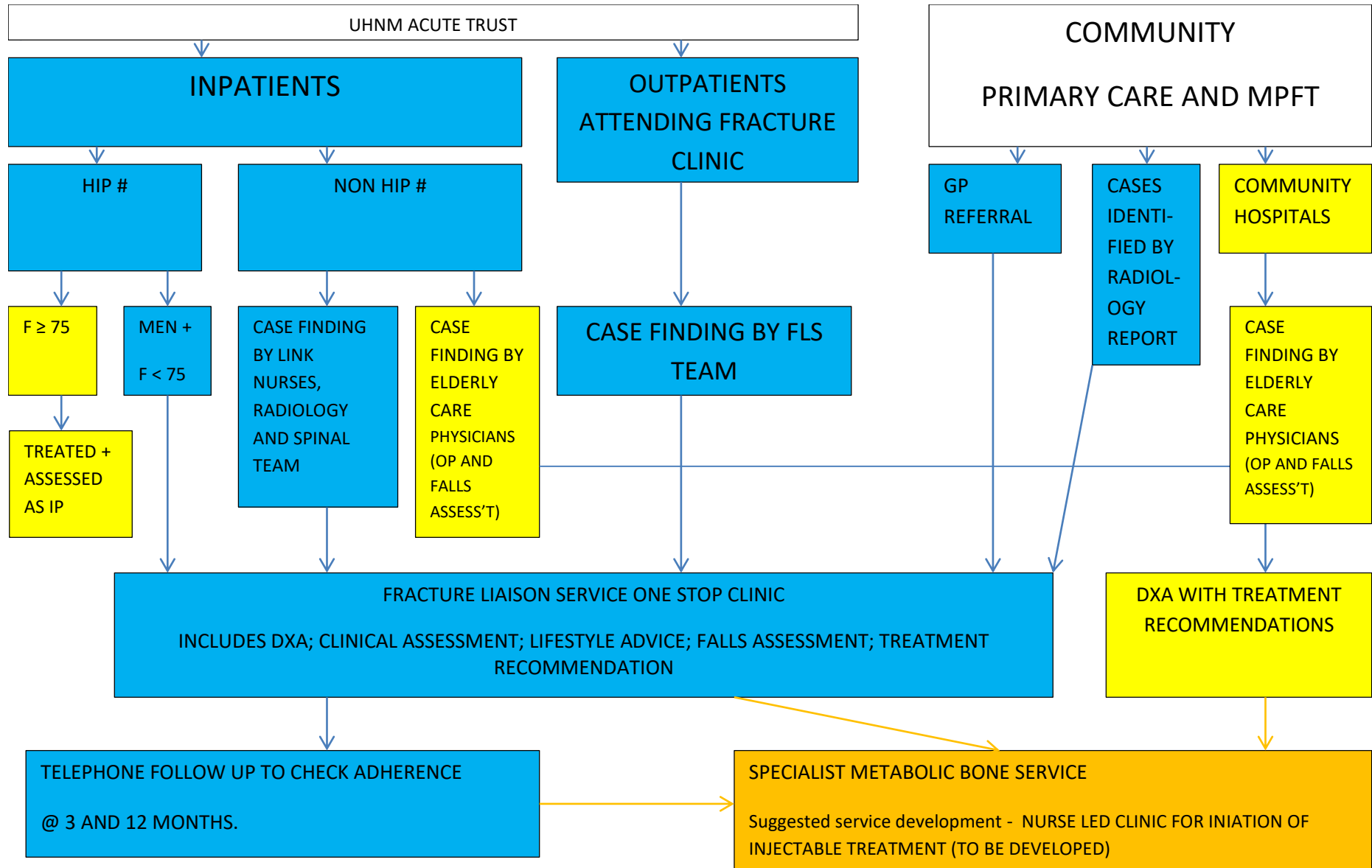
- 80% patients satisfied with the care they receive from the service
- 90% of patients seen within 8 weeks for first appointment

5.2 Applicable CQUIN goals

None

6. Location of Provider Premises

The provider's premises are located at - The Haywood Rheumatology Centre, Haywood Hospital, High Lane, Burslem, Stoke on Trent, Staffordshire ST6 7A



Service Specification No.	CS_42		
Service	Review Health Assessments for Looked After Children (0-4 year olds, 'Hard to Reach' and Care Leavers) North Staffordshire CCG		
Commissioner Lead			
Provider Lead	Lyse Edwards		
Period	1 st April 2022 to 31 st March 2023		
Date of Review	By 31 st March 2023		
1. Population Needs			
1.4 National/local context and evidence base			
1.1.1 There are over 15 million children and young people (CYP) under 20 in England accounting for nearly 25 per cent of the population and of these: • 6 per cent have a disability • 14 per cent have a long standing illness • Over 10 per cent have asthma • 66,000 have autism • 60,000 have epilepsy • 23,000 have diabetes (Source: Children and Young People's Outcomes Forum, 2015) 1.1.2 The number of looked after children (LAC) has continued to rise; it has increased steadily over the last eight years. There were 70,440 looked after children at 31 March 2016, an increase of 1% compared to 31 March 2015 and an increase of 5% compared to 2012. The rise this year reflects a rise of 1,470 in unaccompanied asylum seeking children, compared to a rise of 970 in all looked after children (Department of Education, 2016). 1.1.3 In 2016 the number of looked after unaccompanied asylum seeking children increased by 54% compared to last year's figures, up to 4,210 children at 31 March 2016 from 2,740 in 2015 and up from a low of 1,950 in 2013. At 31 March 2016, unaccompanied asylum seeking children represented 6% of the looked after children population. 1.1.4 Many of these looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers often as a result of poverty, abuse and neglect. The aim is the delivery of services from health agencies to ensure the promotion of the health of looked after children. 1.1.6 Looked-after children and young people should expect to have the same opportunities as other children and young people, including being healthy and safe. They should be provided with the opportunities needed to help them move successfully to adulthood. 1.1.6 The needs of looked-after children and young people vary, but are often complex, and can only be met by a range of services operating collaboratively across different settings. 1.1.7 For children and young people who are looked after, there is a statutory requirement for 0-4 year olds to receive a biannual review health assessment and 5-18 year olds to receive an annual review health assessment (RHA). The RHA is an important feature of addressing the known health inequalities of LAC and in developing an ongoing care plan to address any health needs arising.			
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 2.2.1 Review health assessments (RHAs) are a statutory requirement that Clinical Commissioning Groups are required to provide for Looked After Children (LAC) and should be completed on a bi-annual basis for 0-4 year olds and on an annual basis for children and young people aged 5-18 years. 2.2.2 In order to address the needs of LAC, the provider is expected to: • Provide and equitable service to the population of LAC that the service covers. • Allow LAC to be assessed safely in the most appropriate location, including closer to home • Improve and maintain CYP & parent/carer satisfaction • Ensure LAC receive a high standard of care and an excellent patient experience • Work with other RHA providers to share learning, improve services and reduce variation • Complete RHAs in a timely fashion (as per local pathway timescales). • Complete RHAs to the required quality standard. • Share appropriate information with other relevant agencies regarding the needs of the LAC identified within the RHA. • Contribute towards the reduction in health inequalities experienced by LAC. • Ensure a holistic approach is taken to address the health, social care and emotional wellbeing needs of LAC • Identify and act upon any concerns regarding the safeguarding of LAC and reporting of any concerns in line with the Staffordshire and Stoke-on-Trent Local Safeguarding Board policies and procedures. Focus should also be placed on any LAC that is missing from home/care placement. • Support LAC to increase self-caring abilities and signposting them to a range of local resources that can address any health or social care needs exhibited. • Facilitate transition arrangements for LAC • Provide specific guidance to LAC leaving care regarding their health needs. This will be provided in the form of a booklet documenting key aspects of the LAC's health care needs from their period in care. 2.2.3 Existing separate RHA providers are required to work together to achieve a reduction in variation to assist when children move from one group to another (0-4s to 5-18s or from 'hard to reach' to 'non-hard to reach') or from one area to another. This should include: • Agreeing a consistent referral and assessment process across the whole of Staffordshire to allow for cross boundary working if appropriate. • Development of one shared plan for a child, across the system, where other organisations have an input.			
3. Scope			
3.1 Aims and objectives of service 3.1.1 The aim of the Review Health Assessments for Looked After Children (0-4 year olds, 'Hard to Reach' and Care Leavers) service is to provide a high quality responsive service to LAC (0-4 year olds, 'hard to reach' and care leavers), accessible five days a week and should seek to meet the following objectives: • To work with Staffordshire County Council and Stoke on Trent City Council to provide coordinated and, wherever possible, integrated services. • Establish an effective route for communicating the outcome of the RHA with other services (statutory or voluntary) who are providing support to LAC. • To provide early identification of risk of abuse of LAC who are referred, and act efficiently to minimise the risk of children experiencing harm and promote their wellbeing. • To provide early identification of health needs in LAC who are referred, through the RHA process, offering appropriate advice and support and referral onwards as required. • Ensure that LAC in North Staffordshire and Stoke on Trent are supported and their health needs are met safely in an efficient and timely manner. • To empower families of LAC to lead independent lives. • To work in partnership with families, carers, education, social care and other health professionals working around the child. • To improve the health and life chances for LAC.			

- To safeguard and promote the welfare of the CYP known to the service, giving recognition to the increased vulnerability of children with complex needs.
- To provide guidance during the RHA regarding health promotion resources, statutory health provision and other sources of health care support that could be accessed by the LAC
- To ensure young people are supported through transition into adult services and/or onward into adulthood.
- To work closely with commissioners of services to develop new services and develop services in line with national and local priorities, consultation with service users and guidance and to ensure high quality, effective and value for money services.
- To provide clear, up to date and accessible information and advice to enable LAC and their families/carers to play an active role in the development and implementation of their care plan.
- To improve and maintain the child/young person/parent/care experience.

3.2 Referral Criteria and Pathway

3.2.1 Referral Criteria:

- The CYP must be a LAC.
- The responsible commissioner for the LAC must be one of the following:
 - NHS Stoke on Trent Clinical Commissioning Group
 - NHS North Staffordshire Clinical Commissioning Group
- The LAC must be aged 0-4 years

OR

- The LAC is defined as 'hard to reach':
 - All children not in an education setting (unable to be reached by mainstream school health or home educated)
 - All children not in school but in a LA or Private provider residential accommodation
 - In Prison
 - Semi-independent living (16 and 17 years of age)
 - Difficult over the boundary cases placed by the LA that return by request of the social worker for a RHA
 - Unaccompanied Asylum seekers

OR

- The LAC requires a final RHA at the age of 17 years
- Referrals that do not meet the referral criteria will be redirected to the most appropriate service
- Referral Pathway:
- Referrals can be made by email to a secure nhs.net account.
- Preliminary triage against the referral criteria should be carried out by the service upon receipt of referral from Staffordshire County Council and Stoke on Trent City Council, and the assessment completed within six weeks of the notification.
- Initial contact is made to the foster carers and the LAC's social worker.
- The RHA is completed with referral to other organisations as required. 'Agreement to share information' should be completed.
- The RHA plan is then agreed with the family/carers.
- Referrals to the service can only be made by social workers from Staffordshire County Council.

3.3 Service description/care pathway

3.3.1 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service seeks to provide LAC with a holistic assessment of their physical, emotional and behavioural needs, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps.. The assessment also includes aspects of health education and health promotion, and is known as a Review Health Assessment (RHA). The core focus of this service is:

- LAC 0-4 years
- LAC who are defined as 'hard to reach'

3.3.2 The service will be expected to:

- Develop professional partnerships ensuring the provision of a seamless service for LAC and their families
- Communicate and liaise with the LAC's Independent Reviewing Officer at Staffordshire County Council and Stoke-on-Trent City Council regarding any concerns highlighted during the process of undertaking a RHA.
- Co-ordinate, facilitate and quality assure RHAs in accordance with protocols. Professionals are accountable for maintaining records to ensure timely reviews are undertaken.

- Engage with appropriate translation services as required by LAC to assist the RHA process.
- Promote registration with a General Practitioner (GP) and support this through the LAC's care setting. A copy of the RHA summary and plan should be sent to the GP that the LAC registers with.
- Ensure and maintain robust internal procedures and systems for monitoring health outcomes for children and young people who are looked after.
- Achieve national performance standards for completing RHAs for LAC.
- Provide any LAC leaving care with a "Leaving Care Health Passport" in all cases
- Support uptake of all screening and immunisation programmes for LAC, alongside national programmes.
- All non-attendance of carers/children and/or young person for their RHA review will be notified to their social worker within one working day and recorded in the child's records

3.3.3. In line with national guidance, all RHAs should include:

- an assessment of the child's state of health including his/her physical, emotional and mental health;
- the child's health history including, as far as practicable, the child's family's health history;
- the effect of health and health history on the child's development;
- existing arrangements for medical and dental care, appropriate to the child's needs, including:
 - routine checks of the child's general state of health, including dental health;
 - treatment and monitoring for identified health or dental care needs;
 - preventive measures such as inoculation;
 - screening for defects of vision or hearing;
 - advice and guidance on promoting health and effective personal care; and
- planned changes to current arrangements.

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years. Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments: https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3.3.4 Response times

- Respond within 6 weeks of notification from Staffordshire County Council Staffordshire County Council and Stoke-on-Trent City Council to a referral for a LAC who requires a RHA.
- Negotiate the time of visit with the family
- Notify the family of an attempt to call if they are not in when the nurse visits.
- If a visit or contact is not possible due to service capacity then the Review Health Assessments for Looked After Children service will inform Staffordshire County Council, Staffordshire County Council, Stoke-on-Trent City Council and the CCG.

3.3.5 Care Planning

- Plan, implement, monitor and evaluate programmes of care
- Agree a robust plan of care with the child or young person, parent or carer and multi-agency partners (where necessary) who are involved with the family.

- Develop assessment and RHA plans for children with long term conditions in partnership with family and partners, for all children and young people who are referred to the service.
- Agree a clear management plan based on evidence and informed by national and local protocols, guidelines and pathways
- Provide specialist one to one health advice and support to children and young people in order to promote self-care, where appropriate,
- Provide specialist one to one health advice and support to parents and carers, in order to give them the knowledge and skills to care for the child or young person at home.

3.3.6 Safeguarding

- Work to national safeguarding policies, procedures and guidance and to local Staffordshire Locality Safeguarding Children's Board (LSCB) policies, procedures and guidance.
- Be aware of potential indicators of abuse or neglect and to signpost or refer as appropriate and to implement the Staffordshire Safeguarding Children Board's "Safeguarding Children and Adults at Risk of Abuse or Neglect Policy and Procedure" (SSCB, 2016)
- Be aware of and understand the Staffordshire Safeguarding Children Board's "Early Help Strategy" and implement the use of the "Early Help Tools".

3.3.7 Transition

- Support transition from children's services to adult services, with a particular focus on children and young people with long term conditions, disability or who have life limiting conditions, making use of nationally recommended tools.
- Develop protocols which take into account the maturity of the young person and their social circumstances and allow for flexibility and scope for choice
- Develop protocols which take account of policies and guidance from Staffordshire Local Children's Safeguarding Board (LSCB) "Safeguarding Children and Adults at Risk of Abuse or Neglect Policy and Procedure" (SSCB, 2016)

3.3.8 Continuing Care (Children, Young People and Adults)

- Provide information for children and young people, known to the Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service, as part of the Continuing Care assessment process for children and young people including advice and support for those transitioning from children and young people's services to adult Continuing Care services.

3.3.9 Training (Internal and Staff Development)

- Ensure staff receive regular supervision. This can be received through a combination of group and individual supervision sessions. Supervision should be aligned to role responsibilities and needs of service users and their families.
- Ensure staff meet their NMC revalidation and annual CPD requirements
- Ensure staff undertake all mandatory training requirements-including safeguarding, equality and diversity.
- Ensure that all staff receive appropriate up to date training to enable them to utilise all equipment appropriately.
- Ensure that the workforce is able to meet the needs of the service.

3.3.10 Consultation and Service User Engagement

- Develop a range of methods for engaging children and young people to obtain their views on the service.
- Develop a range of methods for engaging parents and carers to obtain their views on the service.
- Feedback the views of children, young people, parents and carers at appropriate intervals but at least once per year

3.3.11 Commissioning Review Health Assessments for Looked After Children Services

- Work with CCGs in the developmental programmes aimed at extending the effectiveness and cohesiveness of local health and social care provision.

3.4 Population covered

3.4.1 The service covers the following LAC

- All LAC aged 0 to 4 years
- All looked after children aged 0 to 18 years who are defined as 'hard to reach'
- The responsible commissioner for the above categories of LAC must be one of the following:
 - NHS Stoke-on-Trent Clinical Commissioning Group

- NHS North Staffordshire Clinical Commissioning Group
- Be available to this LAC population without regard to gender, sexuality, religion, ethnicity social or cultural determinants.

3.5 Any acceptance and exclusion criteria and thresholds

3.5.1 The service will be available 42 weeks per year within the parameters set out as follows:-

- A service operates between the hours of 8.30am and 5pm, Monday to Friday (core hours) for advice and support and visits as required, but can be flexible to suit the needs of the LAC and their family/carers.

3.5.2 Any LAC who are the responsibility of a local authority other than ones set out in '3.4 Population Covered' are excluded from this service.

3.6 Interdependence with other services/providers

3.6.1 The service will work collaboratively with all those listed below and any other provider or agency involved in the care of the CYP as required. They will work proactively and collaboratively with these agencies to develop robust pathways of care and provide a holistic service.

- The LAC
- Parents and families
- Other carers
- Primary Care:
 - General Practice
 - Secondary/Tertiary Care:
 - Specialist Children's Nurses
 - Acute Paediatricians
 - Neonatologists
 - Specialist Doctors
 - Dieticians
 - Community Care:
 - School Nurses
 - Health Visitors
 - Looked After Children and Family Nurse Partnership
 - Other Providers of children's continuing care packages
 - Physiotherapists,
 - Occupational
 - Therapists
 - Speech and Language
 - Therapists
 - Community Paediatricians
 - Specialist equipment suppliers and loan stores
 - District Nurses
 - Continuing Healthcare
 - Speech and Language Therapy services (SaLT)
 - Others
 - Child and Adolescent Mental Health Services (CAMHS)
 - Learning disability services
 - Special School Nursing
 - Autistic Spectrum Disorder (assessment and intervention) Service Providers
 - Families First
 - Education providers
 - Social Workers
 - Specialist Teachers/SENCOs/Classroom Teachers
 - Early Help
 - Preventative services
 - Short break Staff
 - Palliative Care Consultant/Hospice staff
 - Housing Officers
 - Support groups and local voluntary sector organisations
 - National charities
 - Designated Professional Leads for Safeguarding
 - Education settings
 - Staffordshire Police
 - Staffordshire and Stoke on Trent Local Safeguarding Board
 - Providers of registered children's homes

The above is not an exhaustive list of services and providers are expected to work collaboratively with all relevant services and providers who may contribute to the care of the LAC.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.1.1 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service and advice provided should comply with the following key legislation and guidance:

- Relevant NICE guidelines
- Relevant NPSA and MHRA safety guidance / alerts
- Healthy lives, brighter futures – The Strategy for children and young people's health, DH / DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services DH (2006)
- Transition: getting it right for young people
- The National Service Framework for Long-term Conditions, DH (2005)
- Disabled Children and Young People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- Working Together to Safeguard Children (2015)
- Children Act (2004)
- The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)
- Care Quality Commission Standards
- Promoting the Health and Well-being of Looked After Children (Department of Education and Department of Health, 2015)
- Children Act (1989) – the framework for providing a comprehensive service and support system for children and their families in need of support and protection;
- Crime and Disorder Act (1998)
- Recommendations from The Victoria Climbié Inquiry Report (2003)
- Safeguarding Children in Whom Illness is Fabricated or Induced (Department for Children, Schools and Families, 2008)
- United Nations Convention on the Rights of the Child (United Nations 1990)
- European Convention of Human Rights Articles 6 and 8
- Adoption and Care Leavers Act (2002)
- Foster Care Regulations (2002)
- 0-18 years guidance for all doctors – General Medical Council (2009)
- Sudden unexpected death in infancy: A multi-agency protocol for care and investigation. (Royal College Path and RCPCH 2004)
- Safeguarding Children and Young People: Roles and competences for health staff. (Intercollegiate document, 2014)
- Staying Safe (Department of Health, 2008)
- You're Welcome (Department of Health, 2007 & 2009)
- The Protection of Children Act (1999)
- Framework for the Assessment of Children and their Families (Department of Health, 2000)
- Sharing Information: Practice Guide (DFES 2006)

The above is not an exhaustive list of legislation & guidance and the provider would be expected to keep up to date with all relevant legislation, guidance and NICE guidance.

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

4.2.1 All health organisations must demonstrate how they have listened to the voice of children and young people and how this will be used to improve their health outcomes. *Children and Young People's Health Outcomes Forum (2012)*

4.2.2 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service and advice provided should comply with *The Code (NMC, 2015)*

4.2.3 The first assessment must be carried out by a registered medical practitioner while subsequent assessments may be carried out by a registered nurse or by a registered midwife, so long as this is done under the supervision of a registered medical practitioner [regulation 7(3)]. *The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)*

4.2.4 Health assessments should take place:

- at least once every six months in the case of children aged under five; and
- at least once every 12 months in the case of children aged five and over.

The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)

4.3 Applicable local standards

4.3.1 Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service will meet the priorities and outcomes of the Staffordshire Children, Young people and families Strategy 2016-2026

- Starting well
- Growing well
- Living Well

and

- Happy and healthy
- Safe and belongs
- Achieves and contributes

4.3.2 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service will be expected to comply with all Trust procedures, policies and practices.

4.3.3 Comply with all Staffordshire and Stoke-on-Trent Local Safeguarding Children Board's policies and procedures.

5. Applicable quality requirements and CQUIN goals

5.10 Applicable Quality Requirements (See Schedule 4A-C)

Schedule 6 – Contract Management, Reporting and Information Requirements Reporting Requirements (all Providers other than Small Providers)

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Applica n
Number of referrals to team by referrer	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to coordinating commissioner on the 15 th working day of the month to which it relates MLCSU.nscmt@nhs.net	CS
Number of DNAs	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to coordinating commissioner on the 15 th working day of the month to which it relates MLCSU.nscmt@nhs.net	CS
Number of care leavers provided with exit information pack	Annually	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to coordinating commissioner on the 15 th working day of the month to which it relates MLCSU.nscmt@nhs.net	CS
Number of RHAs completed within timescale	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to	Submit to coordinating commissioner on the 15 th working day of the month to which it relates	CS

		reach', by care leavers	MLCSU.nscmt@nhs.net		
Number of RHAs not completed within timescale and reason	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to coordinating commissioner on the 15 th working day of the month to which it relates MLCSU.nscmt@nhs.net	CS	
Demographics • By gender (male/female) • By ethnic group • By age - o <1 - o 1-4 - o 5-9 - o 10-15 - o 16-18	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to coordinating commissioner on the 15 th working day of the month to which it relates MLCSU.nscmt@nhs.net	CS	
5.11 Applicable CQUIN goals (See Schedule 4D)					
6. Location of Provider Premises					
The service will provided in a variety of settings that are easily accessible and acceptable to looked after children. Given the nature of the proposed users of the service, the provider will be expected to adopt flexibility in how the RHA would be conducted.					
7. Individual Service User Placement					

Service Specification No.	CS_43
Service	Review Health Assessments for Looked After Children (0-4 year olds, 'Hard to Reach' and Care Leavers)
Commissioner Lead	Simon Runnett
Provider Lead	MPFT
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	
1.1.1 There are over 15 million children and young people (CYP) under 20 in England accounting for nearly 25 per cent of the population and of these: • 6 per cent have a disability • 14 per cent have a long standing illness • Over 10 per cent have asthma • 66,000 have autism • 60,000 have epilepsy • 23,000 have diabetes (Source: Children and Young People's Outcomes Forum, 2015) 1.1.2 The number of looked after children (LAC) has continued to rise; it has increased steadily over the last eight years. There were 70,440 looked after children at 31 March 2016, an increase of 1% compared to 31 March 2015 and an increase of 5% compared to 2012. The rise this year reflects a rise of 1,470 in unaccompanied asylum seeking children, compared to a rise of 970 in all looked after children (Department of Education, 2016). 1.1.3 In 2016 the number of looked after unaccompanied asylum seeking children increased by 54% compared to last year's figures, up to 4,210 children at 31 March 2016 from 2,740 in 2015 and up from a low of 1,950 in 2013. At 31 March 2016, unaccompanied asylum seeking children represented 6% of the looked after children population. 1.1.4 In 2016/17 CYP accounted for 21.8% of the overall population of Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds CCG areas (also known as 'South Staffordshire'). 1.1.5 Many of these looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers often as a result of poverty, abuse and neglect. The aim is the delivery of services from health agencies to ensure the promotion of the health of looked after children. 1.1.6 Looked-after children and young people should expect to have the same opportunities as other children and young people, including being healthy and safe. They should be provided with the opportunities needed to help them move successfully to adulthood. 1.1.7 The needs of looked-after children and young people vary, but are often complex, and can only be met by a range of services operating collaboratively across different settings. 1.1.8 The Staffordshire County Council had 991 children in care on the 1st April 2016. 1.1.9 For children and young people who are looked after, there is a statutory requirement for 0-4 year olds to receive a biannual review health assessment and 5-18 year olds to receive an annual review health assessment (RHA). The RHA is an important feature of addressing the known health inequalities of LAC and in developing an ongoing care plan to address any health needs arising.	

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

2.2.1

Review health assessments (RHAs) are a statutory requirement that Clinical Commissioning Groups are required to provide for Looked After Children (LAC) and should be completed on an bi-annual basis for 0-4 year olds and on an annual basis for children and young people aged 5-18 years.

2.2.2

In order to address the needs of LAC, the provider is expected to:

- Provide and equitable service to the population of LAC that the service covers.
- Allow LAC to be assessed safely in the most appropriate location, including closer to home
- Improve and maintain CYP & parent/carer satisfaction
- Ensure LAC receive a high standard of care and an excellent patient experience
- Work with other RHA providers to share learning, improve services and reduce variation
- Complete RHAs in a timely fashion (as per local pathway timescales).
- Complete RHAs to the required quality standard.
- Share appropriate information with other relevant agencies regarding the needs of the LAC identified within the RHA.
- Contribute towards the reduction in health inequalities experienced by LAC.
- Ensure a holistic approach is taken to address the health, social care and emotional wellbeing needs of LAC
- Identify and act upon any concerns regarding the safeguarding of LAC and reporting of any concerns in line with the Staffordshire and Stoke-on-Trent Local Safeguarding Board policies and procedures. Focus should also be placed on any LAC that is missing from home/care placement.
- Support LAC to increase self-caring abilities and signposting them to a range of local resources that can address any health or social care needs exhibited.
- Facilitate transition arrangements for LAC
- Provide specific guidance to LAC leaving care regarding their health needs. This will be provided in the form of a booklet documenting key aspects of the LAC's health care needs from their period in care.

2.2.3

Existing separate RHA providers are required to work together to achieve a reduction in variation to assist when children move from one group to another (0-4s to 5-18s or from 'hard to reach' to 'non-hard to reach') or from one area to another. This should include:

- Agreeing a consistent referral and assessment process across the south of Staffordshire to allow for cross boundary working if appropriate.
- Development of one shared plan for a child, across the system, where other organisations have an input.

3.

Scope

3.1

Aims and objectives of service

3.1.1

The aim of the Review Health Assessments for Looked After Children (0-4 year olds, 'Hard to Reach' and Care Leavers) service is to provide a high quality responsive service to LAC (0-4 year olds,'hard to reach' and care leavers), accessible five days a week and should seek to meet the following objectives:

- To work with Staffordshire County Council to provide coordinated and, wherever possible, integrated services.
- Establish an effective route for communicating the outcome of the RHA with other services (statutory or voluntary) who are providing support to LAC.
- To provide early identification of risk of abuse of LAC who are referred, and act efficiently to minimise the risk of children experiencing harm and promote their wellbeing.
- To provide early identification of health needs in LAC who are referred, through the RHA process, offering appropriate advice and support and referral onwards as required.

- Ensure that LAC in South Staffordshire are supported and their health needs are met safely in an efficient and timely manner.
- To empower families of LAC to lead independent lives.
- To work in partnership with families, carers, education, social care and other health professionals working around the child.
- To improve the health and life chances for LAC.
- To safeguard and promote the welfare of the CYP known to the service, giving recognition to the increased vulnerability of children with complex needs.
- To provide guidance during the RHA regarding health promotion resources, statutory health provision and other sources of health care support that could be accessed by the LAC
- To ensure young people are supported through transition into adult services and/or onward into adulthood.
- To work closely with commissioners of services to develop new services and develop services in line with national and local priorities, consultation with service users and guidance and to ensure high quality, effective and value for money services.
- To provide clear, up to date and accessible information and advice to enable LAC and their families/carers to play an active role in the development and implementation of their care plan.
- To improve and maintain the child/young person/parent/care experience.

Referral Criteria and Pathway

3.2.1 Referral Criteria:

- The CYP must be a LAC.
- The responsible commissioner for the LAC must be one of the following:
 - NHS Cannock Chase Clinical Commissioning Group
 - NHS East Staffordshire Clinical Commissioning Group
 - NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
 - NHS Stafford and Surrounds Clinical Commissioning Group
- The LAC must be aged 0-4 years

OR

The LAC is defined as 'hard to reach':

- All children not in an education setting (unable to be reached by mainstream school health or home educated)
- All children not in school but in a LA or Private provider residential accommodation
- In Prison
- Semi-independent living (16 and 17 years of age)
- Difficult over the boundary cases placed by the LA that return by request of the social worker for a RHA
- Unaccompanied Asylum seekers

OR

- The LAC requires a final RHA at the age of 17 years
- Referrals that do not meet the referral criteria will be redirected to the most appropriate service
- Referral Pathway:
- Referrals can be made by email to a secure nhs.net account.
- Preliminary triage against the referral criteria should be carried out by the service upon receipt of referral from Staffordshire County Council, and the assessment completed within six weeks of the notification.
- Initial contact is made to the foster carers and the LAC's social worker.
- The RHA is completed with referral to other organisations as required. 'Agreement to share information' should be completed.
- The RHA plan is then agreed with the family/carers.
- Referrals to the service can only be made by social workers from Staffordshire County Council.

3.3 Service description/care pathway

3.3.1 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service seeks to provide LAC with a holistic assessment of their physical, emotional and behavioural needs, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps.. The assessment also includes aspects of health education and health promotion, and is known as a Review Health Assessment (RHA). The core focus of this service is:

- LAC 0-4 years
- LAC who are defined as 'hard to reach'

3.3.2 The service will be expected to:

- Develop professional partnerships ensuring the provision of a seamless service for LAC and their families
- Communicate and liaise with the LAC's Independent Reviewing Officer at Staffordshire County Council regarding any concerns highlighted during the process of undertaking a RHA.
- Co-ordinate, facilitate and quality assure RHAs in accordance with protocols. Professionals are accountable for maintaining records to ensure timely reviews are undertaken.
- Engage with appropriate translation services as required by LAC to assist the RHA process.
- Promote registration with a General Practitioner (GP) and support this through the LAC's care setting. A copy of the RHA summary and plan should be sent to the GP that the LAC registers with.
- Ensure and maintain robust internal procedures and systems for monitoring health outcomes for children and young people who are looked after.
- Achieve national performance standards for completing RHAs for LAC.
- Provide any LAC leaving care with a "Leaving Care Health Passport" in all cases
- Support uptake of all screening and immunisation programmes for LAC, alongside national programmes.
- All non-attendance of carers/children and/or young person for their RHA review will be notified to their social worker within one working day and recorded in the child's records

3.3.3. In line with national guidance, all RHAs should include:

- an assessment of the child's state of health including his/her physical, emotional and mental health;
- the child's health history including, as far as practicable, the child's family's health history;
- the effect of health and health history on the child's development;
- existing arrangements for medical and dental care, appropriate to the child's needs, including:
 - routine checks of the child's general state of health, including dental health;
 - treatment and monitoring for identified health or dental care needs;
 - preventive measures such as inoculation;
 - screening for defects of vision or hearing;
 - advice and guidance on promoting health and effective personal care; and
 - planned changes to current arrangements.

3.3.4 Response times

- Respond within 6 weeks of notification from Staffordshire County Council to a referral for a LAC who requires a RHA.
- Negotiate the time of visit with the family
- Notify the family of an attempt to call if they are not in when the nurse visits.
- If a visit or contact is not possible due to service capacity then the Review Health Assessments for Looked After Children service will inform Staffordshire County Council and the CCG.

3.3.5 Care Planning

- Plan, implement, monitor and evaluate programmes of care
- Agree a robust plan of care with the child or young person, parent or carer and multi-agency partners (where necessary) who are involved with the family.
- Develop assessment and RHA plans for children with long term conditions in partnership with family and partners, for all children and young people who are referred to the service.
- Agree a clear management plan based on evidence and informed by national and local protocols, guidelines and pathways
- Provide specialist one to one health advice and support to children and young people in order to promote self-care, where appropriate,
- Provide specialist one to one health advice and support to parents and carers, in order to give them the knowledge and skills to care for the child or young person at home.

3.3.6 Safeguarding

- Work to national safeguarding policies, procedures and guidance and to local Staffordshire Locality Safeguarding Children's Board (LSCB) policies, procedures and guidance.
- Be aware of potential indicators of abuse or neglect and to signpost or refer as appropriate and to implement the Staffordshire Safeguarding Children Board's "Safeguarding Children and Adults at Risk of Abuse or Neglect Policy and Procedure" (SSCB, 2016)
- Be aware of and understand the Staffordshire Safeguarding Children Board's "Early Help Strategy" and implement the use of the "Early Help Tools".

3.3.7 Transition

- Support transition from children's services to adult services, with a particular focus on children and young people with long term conditions, disability or who have life limiting conditions, making use of nationally recommended tools.
- Develop protocols which take into account the maturity of the young person and their social circumstances and allow for flexibility and scope for choice
- Develop protocols which take account of policies and guidance from Staffordshire Local Children's Safeguarding Board (LSCB) "Safeguarding Children and Adults at Risk of Abuse or Neglect Policy and Procedure" (SSCB, 2016)

3.3.8 Continuing Care (Children, Young People and Adults)

- Provide information for children and young people, known to the Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service, as part of the Continuing Care assessment process for children and young people including advice and support for those transitioning from children and young people's services to adult Continuing Care services.

3.3.9 Training (Internal and Staff Development)

- Ensure staff receive regular supervision. This can be received through a combination of group and individual supervision sessions. Supervision should be aligned to role responsibilities and needs of service users and their families.
- Ensure staff meet their NMC revalidation and annual CPD requirements
- Ensure staff undertake all mandatory training requirements-including safeguarding, equality and diversity.
- Ensure that all staff receive appropriate up to date training to enable them to utilise all equipment appropriately.
- Ensure that the workforce is able to meet the needs of the service.

3.3.10 Consultation and Service User Engagement

- Develop a range of methods for engaging children and young people to obtain their views on the service.
- Develop a range of methods for engaging parents and carers to obtain their views on the service.
- Feedback the views of children, young people, parents and carers at appropriate intervals but at least once per year

3.3.11 Commissioning Review Health Assessments for Looked After Children Services

- Work with CCGs in the developmental programmes aimed at extending the effectiveness and cohesiveness of local health and social care provision.

3.4 Population covered

3.4.1 The service covers the following LAC

- All LAC aged 0 to 4 years
- All looked after children aged 0 to 18 years who are defined as 'hard to reach'
- The responsible commissioner for the above categories of LAC must be one of the following:
 - NHS Cannock Chase Clinical Commissioning Group
 - NHS East Staffordshire Clinical Commissioning Group
 - NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
 - NHS Stafford and Surrounds Clinical Commissioning Group
- Be available to this LAC population without regard to gender, sexuality, religion, ethnicity social or cultural determinants.

3.5 Any acceptance and exclusion criteria and thresholds

3.5.1 The service will be available 42 weeks per year within the parameters set out as follows:-

- A service operates between the hours of 8.30am and 5pm, Monday to Friday (core hours) for advice and support and visits as required, but can be flexible to suit the needs of the LAC and their family/carers.

3.5.2 Any LAC who are the responsibility of a local authority other than ones set out in '3.4 Population Covered' are excluded from this service.

3.6 Interdependence with other services/providers

3.6.1 The service will work collaboratively with all those listed below and any other provider or agency involved in the care of the CYP as required. They will work proactively and collaboratively with these agencies to develop robust pathways of care and provide a holistic service.

- The LAC
- Parents and families
- Other carers
- Primary Care:
 - General Practice
- Secondary/Tertiary Care:
 - Specialist Children's Nurses
 - Acute Paediatricians
 - Neonatologists
 - Specialist Doctors
 - Dieticians
- Community Care:
 - School Nurses
 - Health Visitors
 - Looked After Children and Family Nurse Partnership
 - Other Providers of children's continuing care packages
 - Physiotherapists,
 - Occupational
 - Therapists
 - Speech and Language
 - Therapists
 - Community Paediatricians
 - Specialist equipment suppliers and loan stores
 - District Nurses
 - Continuing Healthcare
 - Speech and Language Therapy services (SaLT)
- Others
 - Child and Adolescent Mental Health Services (CAMHS)
 - Learning disability services
 - Special School Nursing
 - Autistic Spectrum Disorder (assessment and intervention) Service Providers
 - Families First
 - Education providers
 - Social Workers
 - Specialist Teachers/SENCOs/Classroom Teachers
 - Early Help
 - Preventative services
 - Short break Staff
 - Palliative Care Consultant/Hospice staff
 - Housing Officers
 - Support groups and local voluntary sector organisations
 - National charities
 - Designated Professional Leads for Safeguarding
 - Education settings
 - Staffordshire Police
 - Staffordshire and Stoke on Trent Local Safeguarding Board
 - Providers of registered children's homes

The above is not an exhaustive list of services and providers are expected to work collaboratively with all relevant services and providers who may contribute to the care of the LAC.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.1.1 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service and advice provided should comply with the following key legislation and guidance:

- Relevant NICE guidelines
- Relevant NPSA and MHRA safety guidance / alerts
- Healthy lives, brighter futures – The Strategy for children and young people's health, DH / DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)

- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services DH (2006)
- Transition: getting it right for young people
- The National Service Framework for Long-term Conditions, DH (2005)
- Disabled Children and Young People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- Working Together to Safeguard Children (2015)
- Children Act (2004)
- The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)
- Care Quality Commission Standards
- Promoting the Health and Well-being of Looked After Children (Department of Education and Department of Health, 2015)
- Children Act (1989) – the framework for providing a comprehensive service and support system for children and their families in need of support and protection;
- Crime and Disorder Act (1998)
- Recommendations from The Victoria Climbié Inquiry Report (2003)
- Safeguarding Children in Whom Illness is Fabricated or Induced (Department for Children, Schools and Families, 2008)
- United Nations Convention on the Rights of the Child (United Nations 1990)
- European Convention of Human Rights Articles 6 and 8
- Adoption and Care Leavers Act (2002)
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- 0-18 years guidance for all doctors – General Medical Council (2009)
- Sudden unexpected death in infancy: A multi-agency protocol for care and investigation. (Royal College Path and RCPCH 2004)
- Safeguarding Children and Young People: Roles and competences for health staff. (Intercollegiate document , 2014)
- Staying Safe (Department of Health, 2008)
- You're Welcome (Department of Health, 2007 & 2009)
- The Protection of Children Act (1999)
- Framework for the Assessment of Children and their Families (Department of Health, 2000)
- Sharing Information: Practice Guide (DFES 2006)

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years. Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Safeguarding

The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments: https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

The above is not an exhaustive list of legislation & guidance and the provider would be expected to keep up to date with all relevant legislation, guidance and NICE guidance.

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

- 4.2.1 All health organisations must demonstrate how they have listened to the voice of children and young people and how this will be used to improve their health outcomes. *Children and Young People's Health Outcomes Forum (2012)*
- 4.2.2 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service and advice provided should comply with *The Code (NMC, 2015)*
- 4.2.3 The first assessment must be carried out by a registered medical practitioner while subsequent assessments may be carried out by a registered nurse or by a registered midwife, so long as this is done under the supervision of a registered medical practitioner [regulation 7(3)]. *The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)*
- 4.2.4 Health assessments should take place:
- at least once every six months in the case of children aged under five; and
 - at least once every 12 months in the case of children aged five and over.
- The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)*

4.3 Applicable local standards

- 4.3.1 Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service will meet the priorities and outcomes of the Staffordshire Children, Young people and families Strategy 2016-2026
- Starting well
 - Growing well
 - Living Well
 - Happy and healthy
 - Safe and belongs
 - Achieves and contributes
- 4.3.2 The Review Health Assessments for Looked After Children (0-4 year olds and 'Hard to Reach') service will be expected to comply with all Trust procedures, policies and practices.
- 4.3.3 Comply with all Staffordshire and Stoke-on-Trent Local Safeguarding Children Board's policies and procedures.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

Schedule 6 – Contract Management, Reporting and Information Requirements - A Reporting Requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Number of referrals to team by referrer	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Number of DNAs	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Number of care leavers provided with exit information pack	Annually	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Number of RHAs completed within timescale	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Number of RHAs not completed within timescale and reason	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS
Demographics • By gender (male/female) • By ethnic group • By age • <1 • 1-4 • 5-9 • 10-15 • 16-18	Quarterly	Excel spreadsheet; split by month, by CCG, by 0-4 year olds, by 'hard to reach', by care leavers	Submit to Coordinating Commissioner within 15 Operational Days of the end of the month to which it relate.	CS

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The service will provided in a variety of settings that are easily accessible and acceptable to looked after children. Given the nature of the proposed users of the service, the provider will be expected to adopt flexibility in how the RHA would be conducted.

7. Individual Service User Placement

Service Specification No.	CS_44
Service	Provider Improvement and Response Team
Commissioner Lead	Staffordshire and Stoke-on-Trent CCGs
Provider Lead	Midlands Partnership NHS Foundation Trust
Period	April 2022 – March 2023
Date of Review	31 st March 2023

1. Background

1.1 Purpose

PIRT is jointly funded by Staffordshire County Council (SCC) and the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCG's). The team works with residential care homes and nursing care homes who meet the criteria for support. The team does not duplicate the work of the Care Quality Commission (CQC) as the team is focused on assurance, support and improvement. PIRT does not have any regulatory function.

1.2 Areas of operation

The team operates across Staffordshire and Stoke-on-Trent, covering the districts and boroughs of Staffordshire (Staffordshire Moorlands, Newcastle-under-Lyme, Stafford, Cannock Chase, South Staffordshire, East Staffordshire, Lichfield and Tamworth) and also provides nursing support to care homes in Stoke-on-Trent.

1.3 Hours of Operation

The PIRT's normal working pattern is Monday to Friday in standard working hours (as per each organisation's policies). However, there is a requirement to work evenings and weekends when urgent concerns arise, by exception. This requirement is reflected in all job descriptions for the PIRT. Any work completed outside of core hours will be subject to the policies and procedures from each employing organisation that cover overtime, flextime and enhanced payments.

1.4 Working with Stoke Local Authority

Stoke Local Authority do not contribute financially to the PIRT. However, Stoke CCG do and therefore the clinical element of the team is expected to cover the Stoke Local Authority area. Any changes or developments to the working relationship for PIRT with Stoke will be managed by SCC directly with Stoke on Trent City Council.

1.5 Support cycle

The team will support care homes until a point where they no longer meet the criteria for support, at which point the support process will be considered complete or the process will be handed back to the relevant Quality Assurance Team.

2 Team Overview

2.1 Team Structure

Operational management and oversight is provided by the SCC Quality Assurance Team Leader. Clinical oversight is provided by MPFT.

The team structure is:

Fig1

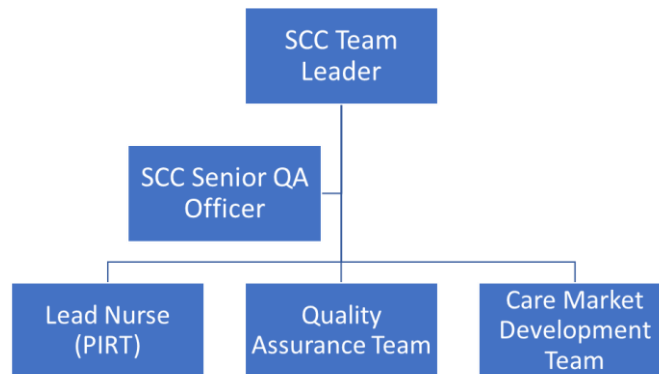


Fig2

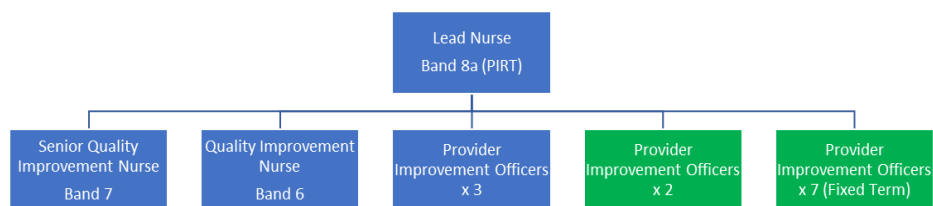
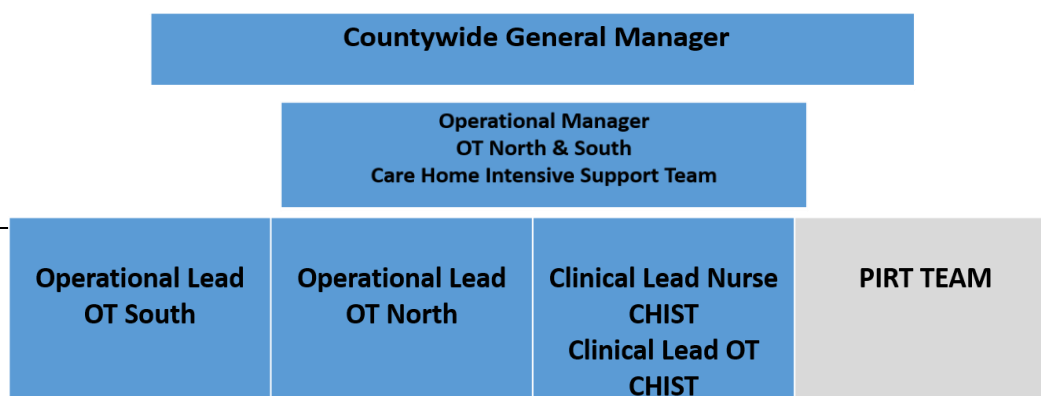


*Fig2 – The blue boxes denote PIRT staff joint funded. The green boxes denote additional staff funded by SCC only.

The team is line managed as part of the Local Authority Care Commissioning function, reporting into the Assistant Director for Care Commissioning.

Within this document the term 'management team' will refer to the SCC Quality Assurance Team Leader, the SCC Senior Quality Assurance Officer and the Lead Nurse for the Provider Improvement Response Team (PIRT).

MPFT Structure:



2.2 Roles and Responsibilities

2.2.1 Quality Assurance Team Lead

The team is overseen by the Team Leader for SCC's Quality Assurance Team. The Team Leader reports to the Lead Commissioner for Market Management and Quality Assurance. The Team Leader has overall strategic, operational and line management responsibility for the PIRT. The Team Leader will work closely with the Operational Manager/Lead designated for PIRT within MPFT. This will involve sharing of information, regular updates regarding the team and liaison with any governance requirements.

2.2.2 Senior Quality Assurance Officer

The Senior Quality Assurance Officer deputises for the Team Leader and supports the team leader in all aspects of the management of the quality assurance function, including the PIRT.

2.2.3 Lead Nurse

The Lead Nurse provides day to day management to the team. Is responsible for allocation of services to each team member's portfolio and for managing the overall workload of the team. Provides supervision to the team members and line manages the nurses and officers. Provides support and guidance to care providers and reports to the Team Leader.

The Lead Nurse is responsible for clinical oversight of the quality improvement nurses, as well contributing to the strategic development of the team.

2.2.4 Senior Quality Improvement Nurse

The Senior Quality Improvement Nurse visits care homes and offers support and guidance to care providers. This role is line managed by the Lead Nurse or in the absence of the Lead Nurse they will report to the Team Leader. The Senior Nurse will deputise for the Lead Nurse and will have responsibility for more complex escalations.

2.2.5 Quality Improvement Nurse

The Quality Improvement Nurse visits care homes and offers support and guidance to care providers.

2.2.6 Provider Improvement Officer

The Provider Improvement Officers visits care homes and offers support and guidance to care providers.

The employing agency for the nurses will be MPFT, which includes the Lead Nurse, Senior Quality Improvement Nurse and Quality Improvement Nurse. The employing agency for the PIRT officers will be SCC.

3 Policies and Procedures

SCC will be responsible for the production, maintenance and development of all operational policies and procedures for the team. This will however, take into consideration any specific guidance applicable from MPFT. This is particularly relevant for clinical guidance. MPFT will share with SCC any policies or procedures necessary to help manage the nurse roles, as part of the wider team. This includes, but is not limited to, those relating to:

- People Management
- Health and Safety, including lone working
- Clinical Escalation Aims and objectives of the service
- Documentation and record keeping (when applicable to the nurses)

MPFT will provide an on-going local contact, and point for escalation, for the management team to ensure advice, guidance and policies and procedures can be accessed at all times.

4 People Management

4.1 Line Management

Line management responsibility for the team sits with the management team as set out in the team structure chart. This includes all day-to-day team issues, as well as management of sickness, performance and leave. The management team will have to work across SCC & MPFT policies and processes. The 3 nurses are employed by MPFT and therefore will be managed in accordance with MPFT policies. Any formal escalations will be managed jointly between SCC and MPFT. MPFT will provide SCC with a point of contact for HR advice and guidance.

4.2 Sickness

The management team will be responsible for completing return to work (RTW) interviews with all staff in the team. The management team will manage the absence in accordance with the employing agencies policy and associated documentation. For MPFT staff this will be in accordance with the MPFT Managing Attendance Policy and Procedure and associated documentation. The paperwork will be saved as part of the management team files and in the case of nurses, sent to MPFT to be input into the Electronic Staff Records (ESR) system. If a team member's level of absence requires escalation or action, then the management team will refer to MPFT HR policies for direction. The management team will carry out any formal escalations jointly with MPFT. Any documentation from such meetings will be saved to the management team folders and also shared with MPFT. Any decisions on formal action will be made jointly between the management team and MPFT.

4.3 Leave

The management team will be responsible for authorising and managing leave within the team. This will include annual leave and also other types of leave, e.g. compassionate.

Decisions on authorising leave will be made in accordance with MPFT policies and procedures. Once authorised, nursing staff will be required to input their annual leave into MPFT's Health Roster system for on-going record. The management team will keep a local record for the nurses and use SCC's HR system for monitoring the officers. The PIRT will be expected to maintain cover at all times of the year, including Christmas to ensure a response to urgent concerns as required. However, at times when the demand for annual leave is highest, it is accepted that the PIRT will have reduced staff availability at these times. Decisions of rolling annual leave will be made the Team Leader, but subject to policies and procedures of MPFT.

At the start of each leave year MPFT will update the management team on leave entitlements for the nursing staff.

4.4 Risk Assessment and Occupational Health

The management team will be responsible for completion of all necessary risk assessment documentation. This will include risk assessments to support wellbeing as well as operational risk assessments (e.g. lone working). They will also be responsible for the review and monitoring of any such risk assessments. The management team will make any necessary requests for occupational health input. The management team can't raise these directly within the MPFT system, so they will work collaboratively with the designated MPFT Operational Manager/Lead to ensure the relevant information is input and processed as required. The responsibility for ensuring this process meets the MPFT policy and procedure requirements will be with MPFT. The management team will be required to ensure that any required narrative or detail is shared with MPFT. The management team will be responsible for ensuring control measures are in place as outlined in any risk assessments. They are also responsible for considering any recommendations from an occupational health referral in conjunction with the MPFT Operational Manager/Lead. Should there be any dispute over the ability to implement any recommendations from an occupational health referral, the final decision is with the Team Leader in consultation with MPFT's Operational Manager/Lead and HR team as required. The management team will keep all associated documentation and reports pertaining to the PIRT and these will be shared with MPFT. The nurses will be able to access all the current support mechanisms that MPFT offer to their staff, e.g. physiotherapy, resources etc.

4.5 Performance Management

The management team will be responsible for the overall team's performance, as well as that of individual team members. If concerns arise regarding an individual team members performance this will be managed in line with MPFT's associated policy and procedure. For any concerns that require formal action, the management team will carry out any formal escalations jointly with MPFT. Any documentation will be saved to the management team folders and also shared with MPFT. Any decisions on formal action will be made jointly between the management team and MPFT.

4.6 Recruitment

The management team will be responsible for the recruitment of all staff both officers and nurses. For officers, the management team will follow SCC recruitment procedures. For the recruitment of nurses, this will be done jointly with MPFT. The management team will draft adverts and use the agreed Job Description's (JD's) for the recruitment of nurses. MPFT will support with finalising the advert content and advertising the vacancies via MPFT's processes. The interview panels will be led by the management team with a representative from MPFT. SCC interview templates will be used and the content of the interview will be jointly agreed

between SCC and MPFT to ensure the values and behaviours of MPFT are reflected. Records of interviews will be kept by the management team.

Appointment, recruitment checks (including DBS, references, professional registration) and contract documents will be completed and issued by MPFT through liaison with the management team. All documents issued by MPFT will be shared with the management team for record. Any concerns highlighted through recruitment checks will be shared with the management team. The management team will have the final decision about recruitment, following advice from MPFT's HR team. This may also include the completion of any required risk assessments prior to appointment e.g., positive DBS disclosure. The management team will be required to make recruitment decisions in line with MPFT's policies and procedures.

4.7 Induction, Training and Development

The management team will complete inductions for all new staff. The content of this will be a combination of both SCC and MPFT requirements. The management team will ensure the requirements of both organisations policies and procedures are adhered to. For the nurses they will complete standard induction requirements for both SCC and MPFT. The local, role specific, induction will be the responsibility of the management team. For mandatory training, the same principle will apply that the nurses complete mandatory training requirements across both organisations. Continuous professional development training for the nurses will be determined jointly between SCC and MPFT. The nurses will be able to access training across both organisations. The management team will be responsible for ensuring staff complete the necessary training for their roles. Opportunities for clinical development and mentoring for the nurses will be provided by MPFT as appropriate.

4.8 Equipment and Items required

ICT equipment will be provided by SCC due to the need to access and work on Local Authority systems and servers. ID badges will be supplied by MPFT. The PIRT nurses will also need to have an ID badge from SCC to allow access to the buildings, printers etc., so this will also be provided. Uniforms for the nurses will be provided by MPFT in line with their uniform policy. Nurses will need access to MPFT systems for entering annual leave, travel expenses, completing statutory training courses and clinical systems. The nurses will access these systems via cloudPC and SMART cards. This will allow the nurses to access the necessary applications via a web browser. The SMART cards and USB SMART card readers for the nurses will be provided by MPFT. The costs of the SMART cards will be absorbed through the allocated MPFT expenses budget.

4.9 Expenses

For mileage and other travel expenses, the nurses will log expenses incurred via MPFT's Health Roster system which is authorised by MPFT's the operational lead, via confirmation of the management team. For officers, the Team Leader will authorise any travel expenses incurred via the HR system. The base for mileage for both the nurses and officers has been agreed as Staffordshire Place 1, Stafford (SCC building).

Additional adhoc requests for expenses needed for the team will need approval by the management team. The nurse/officer will then submit that request to the employing agency in line with their policies and procedures.

4.10 Supervision and One to One's

The management team will have responsibility for completing supervision with staff. The format and frequency of supervision will be determined by the management team in line with MPFT's policies and procedures for the nurses. The Team Leader will complete regular

supervision with the Lead Nurse. The supervision of the rest of the team will be completed by the Lead Nurse/Senior Quality Improvement Nurse. The Lead Nurse will also require clinical supervision and development which will be provided by the Professional Lead for Nursing from MPFT. The nurses must ensure they keep up to date with their professional registration and revalidation requirements. Support for the revalidation process will be provided by MPFT in line with the professional registration policy.

MPFT will provide a designated Operational Manager/Lead for the PIRT. The Operational Manager/Lead will meet regularly with the Lead Nurse and discuss on-going clinical supervision and development requirements. The Lead Nurse will complete clinical supervision for the other nurses in the team.

4.10.1 MPFT Supervision Requirements

Managerial

Monitoring of individual performance at work to ensure that it is safe, effective and in accordance with statutory and organisational requirements and priorities including activity and tasks in the workplace including identifying risks associated with the workload being undertaken

This will be completed by the PIRT management team, and any escalations/concerns will be discussed with the Operational Manager/Lead for MPFT for action.

Professional

Regular structured opportunity for people to engage in facilitated reflection on their practice. Supervision encourages individuals to assume responsibility for developing and maintaining their skills and competence including their self-assessment analytic and reflective skills.

This will be completed by the Lead Nurse for the Senior QI Nurse and the QI Nurse. The professional lead will complete a monthly supervision for the Lead Nurse.

Clinical

Recognize the demanding and sometimes distressing nature of working in health and social care and providing guidance in developing and maintaining effective strategies for managing the emotional and psychological impact of the work.

This will be completed by the PIRT management team, and any escalations/concerns will be discussed with the Operational Manager/Lead for MPFT for action.

Any other additional supervision requirements from MPFT, including safeguarding, will be communicated to the management team. A joint discussion and decision will be taken on who is best to complete the requirements with the members of the team. We will agree the following joint principles for supervision:

- The management team will determine the frequency of supervision with consideration of the MPFT's supervision policy.
- It is an open and supportive process that is an essential part of practice
- Is a collaborative process in which individuals actively engage and take responsibility.
- Supervision should enable employees to reflect on, analyse and evaluate their own practice.
- It will occur at regular intervals and be recorded.

- Effective supervision should enable employees to develop knowledge, skills, competences and values required for their role.
- Staff will be offered training to ensure they are skilled and competent to support others in supervision activity

4.11 Appraisals

SCC and MPFT will conduct joint appraisals of the nurses. This will be in line with MPFT's policy and procedure. MPFT will notify SCC when appraisals are required to be completed so that can be planned into the work schedule.

5 Financial Arrangements and Employment Responsibilities

5.1 The funding arrangement for the PIRT is a joint funding agreement between SCC and the CCG's. Both parties agree to fund pay plus on-costs and direct expenses including mileage, uniforms and ICT on a 50/50 basis for 6 personnel in total (3 nurses and 3 officers). A financial transaction will occur between the CCG's and SCC to enable the CCG's to make payment to MPFT of the full amount as set out below.

5.2 The CCG's fund the overhead costs for the 3 nurses in their entirety, as part of the wider MPFT contract.

5.3 CCGs will pay MPFT £179,516 (at 2022/23 prices) covering the following costs:

Pay plus on-costs for following staff:

- Lead Nurse (Band 8a)
- Senior Quality Improvement Nurse (Band 7)
- Quality Improvement Nurse (Band 6)
- Direct costs e.g. mileage, occupational health, training, IT accounts, evening/weekend working.
- Overheads e.g. Payroll, HR administration, clinical supervision,

5.4 Funding will be subject to annual Agenda for Change pay growth and inflation and SCC annual pay growth and inflation. Any other additional costs (including overheads) will need to be discussed and agreed year on year jointly between all parties, including SCC.

5.5 This service specification covers the nursing element of the PIRT service. Any changes to the PIRT service, including team structure, functions or remit must be with consultation and agreement of both the CCG's and SCC.

Service Specification No.	CS_54																			
Service	Children's Physiotherapy																			
Population and/or geography to be served	<u>1.0 Population Covered</u> The service will be available to children and young people aged 0-18 years of age (includes those in full time education up to the day of their 19th Birthday and those with an EHCP up to the day of their 25th birthday) and who are registered with a GP within the geographical boundaries of Staffordshire and Stoke on Trent (excluding East Staffordshire CCG area).																			
Service aims and desired outcomes	<u>2.0 NHS Outcomes Framework Domains and Indicators</u> <table border="1"> <tr> <td>Domain 1</td><td>Preventing people from dying prematurely</td><td></td></tr> <tr> <td>Domain 2</td><td>Enhancing quality of life for people with long-term conditions</td><td>√</td></tr> <tr> <td>Domain 3</td><td>Helping people to recover from episodes of ill health or following injury</td><td>√</td></tr> <tr> <td>Domain 4</td><td></td><td>√</td></tr> <tr> <td>Domain 5</td><td>Ensuring that people have a positive experience of care</td><td>√</td></tr> <tr> <td></td><td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td><td></td></tr> </table> <u>2.1 Local Defined Outcomes</u> 2.1.1 The service will contribute to the outcome identified within the Staffordshire Children's and Young People (CYP) Families Strategy 2016 that CYP will be: • Happy and healthy • Feel safe and belong • Achieve and contribute 2.1.2 The strategy prioritises: • Starting well – every child has the best possible start in life to reduce difference in the quality of people's health and wellbeing in the future • Growing Well – CYP are supported to reach their potential so that they can have greater control over their lives • Learning Well – CYP and adults are supported to make good lifestyle choices 2.1.3 The particular benefits to CYP in receipt of community physiotherapy services and their families and carers include: • A comprehensive range of services will be delivered within local communities, school settings or at 'closer to home' locations • Other members of the children's workforce e.g. teachers and education support will feel confident to meet the needs of children with physical difficulties • CYP, parents and carers will be supported and empowered to manage the CYP's condition • CYP, parents, carers and educational staff are able to undertake ongoing programmes of interventions with support from the physiotherapy team • The smooth transition of adolescents to adult physio services as appropriate • Disabled children/children with physical difficulties will be able to participate fully in their home and education learning settings, through direct and indirect interventions to upskill families/carers/practitioners • Motor function and independence will be improved through early identification, assessment and intervention and provision of high quality input from skilled staff		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		√	Domain 5	Ensuring that people have a positive experience of care	√		Treating and caring for people in a safe environment and protecting them from avoidable harm	
Domain 1	Preventing people from dying prematurely																			
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Domain 3	Helping people to recover from episodes of ill health or following injury	√																		
Domain 4		√																		
Domain 5	Ensuring that people have a positive experience of care	√																		
	Treating and caring for people in a safe environment and protecting them from avoidable harm																			

	• Access to assessment for specific appropriate adaptations and equipment allowing the CYP to functions as independently as possible considering their physical abilities, provided the CYP has an active care plan with the service • Appropriate contributions by the physiotherapy team will be made to Special Educational Needs and Disability (SEND) assessments, Educational Health Care Plans (EHCP) and assessments • Improved quality of life <u>2.2 Aims and Objectives of Service</u> 2.2.1 The aim of the community paediatric physiotherapy service is to support CYP to reach their full potential of maximising functions and movement whilst increasing independence using a CYP family centred approach 2.2.2 The service will be delivered through: • Physiotherapists who are Allied Health Professionals and registered with the Health Care Professions Council and qualified to assess and diagnose, utilising physiotherapy support staff • Supporting CYP to reach their full movement and functional potential using an evident based approach • Supporting and encouraging CYP to develop their physical condition in order to become as independent as possible in childhood and adulthood • Promote functions and movement to achieve expected level for the CYP's developmental stage • Prevent or limit contractures and deformity • Striving to improve CYP's quality of life
Service description and location(s) from which it will be delivered	<u>3.0 Service Description Care Pathway</u> Paediatric physiotherapy is the treatment of physical conditions seen in children which affect or compromise normal physical childhood development. • The physiotherapy service will provide CYP and family centred services that recognise and build upon a CYPs strengths and focuses on improving outcomes • CYP whose needs can be met by universal or targeted services and are low risk are not offered direct therapy. Instead, these CYP will be signposted for support into universal-targeted services or offered advice only. This service model ensures that only those CYP with a specific need for therapeutic intervention receive a specialist service • Intervention is underpinned by care plans and outcome measures following evidence-based research • The service will manage caseloads and co-ordinate care, discharging and referring CYP as appropriate • The service will contribute to common assessments and integrated support plans as part of Early Help Assessments and will use information from other assessments to inform the physiotherapy care plan <u>3.1 Assessment</u> The community paediatric physiotherapy service will: • Provide functional needs led assessment of CYPs motor ability • Assess CYPs ranges, patterns and quality of movement • Assess average clinical risk for CYP • Contribute to 24 hours postural care management and assessments • Provide clear feedback to the CYP, parent/carer, the referrer and the CYPs educational setting. This should include the assessment outcome, functional goals agreed, the recommended intervention, management advice and guidance and information regarding available training

- Deliver assessment in the most appropriate and accessible functional context for the CYP eg clinics, educational settings, CYPs home
- Set functional goals involving the CYP, parents/carers and educational providers
- Use of outcome measures for every child looking at reducing clinical risk by physiotherapy intervention. Every child will have an outcome measure and clinical risk score assigned

3.2 Intervention

The community paediatric physiotherapy service will:

- Deliver interventions that have a functional impact and/or improve quality of life that are outcome focussed with outcome measures agreed with the CYP
- Intervention will be provided at the most optimum time in a CYPs pathway where the greatest positive impact can be made
- Deliver interventions that are evidence based
- Deliver interventions that are flexible and accessible and build upon the strengths of the CYP
- Provide training for parents/carers and educational staff to enable them to contribute to the effective delivery of interventions for the CYP
- May involve direct intervention from a physiotherapist or an indirect approach of enabling others to meet the needs of the child through delivery of a specific general programme
- CYP who undergo Selective Dorsal Rhizotomy (SDR) surgery having met NHS criteria for surgery will receive pre and post-surgical care
- Possible interventions may include but are not exclusive to:
 - Treatments such as bobath, handling and facilitation techniques,
 - exercise programmes
 - programmes, strength training
 - Spasticity assessments and management
 - Handling facilitation techniques
 - Exercise programmes
 - Teaching of activities and skill sharing
 - Recommendation for assessment of orthotics
 - Assessment for specialist equipment
 - Conducting awareness sessions
 - Provide specialist input into clinics run by other professionals including but not exclusive to orthopaedic consultant clinics and orthotic clinics

3.3 Intervention Plans

- Following an assessment, if required an individual Intervention Plan is developed
- The plan is robust involving the CYP, family/carers, and multi-agency partners where necessary. Initially, therapists will teach parents/carers, educational providers about the CYPs condition and support them to provide the necessary care. As the CYP grows older the therapist will encourage them to manage their condition whilst providing a more advisory model of care
- An episodic approach of input if often required which is goal-orientated and focused on times of change in the CYPs life including but not exclusive to surgery, growth and transition between educational settings

3.4 Evaluation

The community paediatric physiotherapy service will:

- Evaluate the achievement of agreed functional outcome measures for each CYP
- Use outcome measured evaluation data to drive continuous service improvement
- Participate in national and local evaluation research
- Seek patient/user and parent/carer feedback

3.5 Transition

The community physiotherapy service will:

- Assist to facilitate the transition from paediatric services to adult services making use of national tools
- Assist the CYP with transition within educational environments

3.6 Response Times and Prioritisation

The community paediatric physiotherapy service will adhere to the national referral to treatment 18-week target while providing CYP with access to the service in accordance with their identified risk:

- Risk identified as urgent: access within 2 weeks
- Risk identified as routine medium: within 8 weeks
- Risk identified as routine low: within 12 weeks

3.7 Core service hours

The service will operate from 8.30 – 16.30 five days a week, Monday to Friday, excluding bank holidays. Some out of hour's appointments may be required to meet the needs of the individual child and family.

3.8 Referral Criteria

3.8.1 The service includes specialist intervention for CYP who present with physical difficulties that compromise their motor development or function.

3.8.2 The physiotherapy service will only accept referrals from medical and healthcare professionals which include but are not exclusive to:

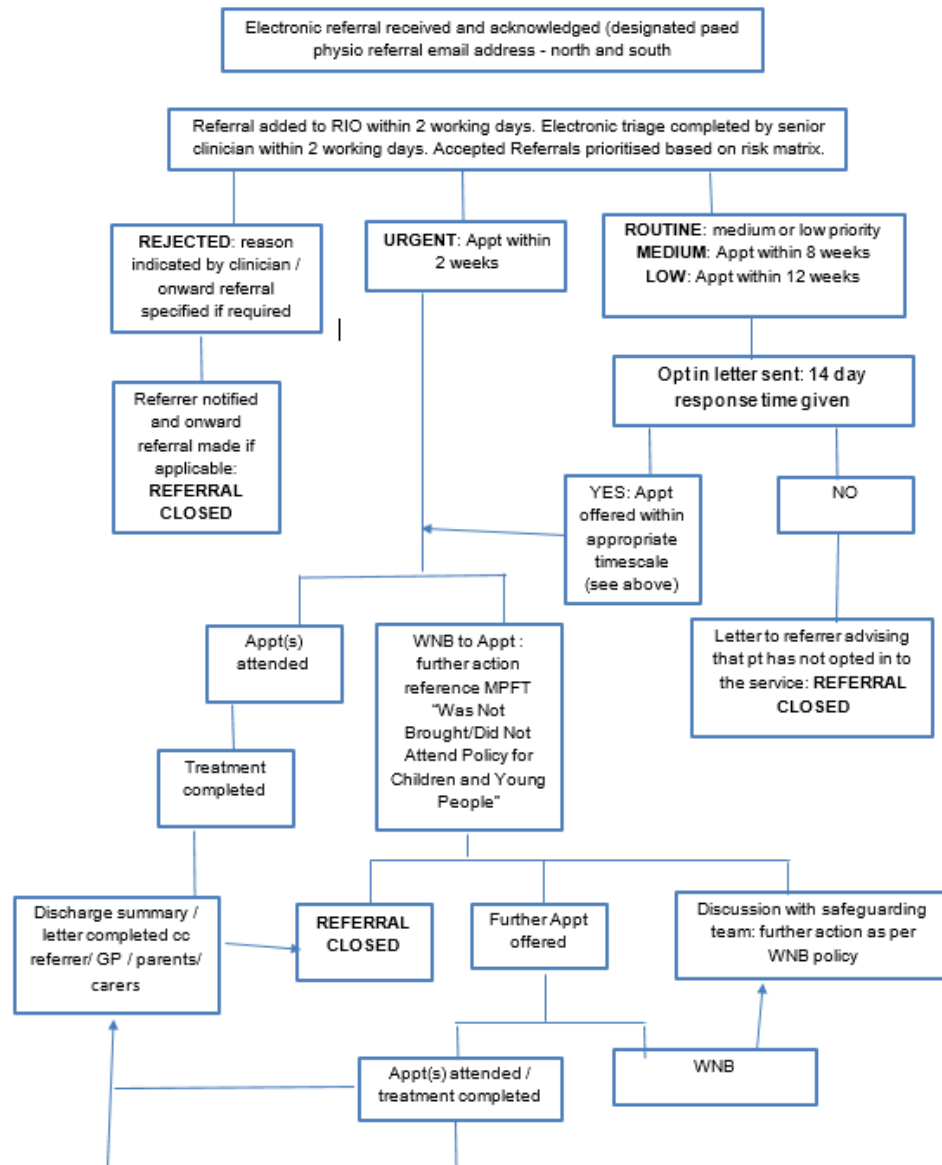
- GPs
- Health Visitors
- Children's Community Nurses
- School Nurses
- Acute and Community Paediatric Services
- Other Allied Healthcare Professionals

3.8.3 Referrals that do not meet the referral criteria, incomplete referral forms or forms with limited detail will be recorded and communicated/returned to the referrer.

3.8.4 CYP 0-18 years can access the service. The service can be extended for services users up to 25 years where there is a complex health need, special education needs or disability and/or an EHCP, noting a physiotherapy need and no identified team has been recognised to meet the needs of the CYP.

3.8.5 Young people with an MSK issue will be referred to and treated within the paediatric physiotherapy service.

3.9 Referral Pathway



3.10 Risk matrix

Potential / Actual impact on the child's function

High impact	4				
Moderate impact on Function	3				
Mild impact	2				
No or negligible impact on function	1				
		1	2	3	4
		Unlikely to achieve a lasting benefit from PT or likely to progress without PT intervention	Possible benefit from PT but likely to progress following PT advice and needs then met by family and setting	Likely to achieve significant and lasting benefit from specific PT intervention/ unlikely to make spontaneous progress	Highly likely to achieve major benefit and/or condition will worsen without specific PT

Likelihood of a positive outcome from PT intervention working within the existing service specification

HIGH IMPACT on FUNCTION	- Indicates a significant physical disability requiring full assistance with completion of ADL's. Little or no independence. (POTENTIAL FOR SIGNIFICANT LONG TERM IMPLICATIONS) - Conditions may include: CP GMFCS Level IV & V, Significant Development Delay. - Neuromuscular conditions which have resulted in little or no ambulation - Post Op – Multilevel surgery, SDR, ~~botox~~ etc. - Neck or back with red flags - Newly diagnosed/ very unstable neuro - Neonate/~~Prem~~ baby – referred from neonatal team. - Child with significant levels of pain or significant functional impact. - Delayed receipt of referral (with reference to condition / clinical reasoning) - Plagiocephaly with/without torticollis/head turning preference - Brachial plexus lesion ~~Talipes~~ over 3 months old - Re-referral/self-referral for urgent follow up as indicated by lead clinician
MODERATE IMPACT on FUNCTION	- A physical disability where only some independence is present. There would be potential for deterioration and/or the POTENTIAL FOR SOME, BUT NOT SIGNIFICANT LONG TERM IMPLICATIONS - Conditions may include: CP GMFCS level III, Ambulant Neuromuscular conditions, - Significant/Moderate developmental delay – may be ~~ass'd~~ with other condition ~~eg~~ Down's Syndrome ~~Prem~~ baby born at 32 weeks or under - Young (0-2) or newly diagnosed neuro. - Older 2+ but unstable/new issue neuro - MSK with high/moderate levels of pain - MSK with high/moderate functional impact - High/moderate symptomatic Hypermobility ~~Talipes~~ under 3 months old - DCD with high/moderate levels of impact - Gait abnormalities with red flags ~~eg~~ bilateral ~~intoeing~~ with toe walking, hip pain, limp, constant toe walkers unable to get heels down, asymmetry - Delayed receipt of referral if not considered for urgent category
MILD IMPACT on FUNCTION	- Independent mobility. Minimal assistance with ADL's (age appropriate) MINOR IMPAIRMENT WITH LITTLE OR NO LONG TERM IMPLICATIONS - Conditions may include: CP GMFCS Level I & II, - Mild developmental delay - Uncomplicated MSK with no/low level of pain, functional impact or concerns over future impact - Asymptomatic or minimally symptomatic hypermobility. - DCD with low levels of impact - Gait abnormalities without red flags – intermittent toe walkers, frequent falls/tripping - Unspecified Coordination concerns with low level impact

3.11 Any Acceptance and Exclusion Criteria and Thresholds

Exclusion criteria for the service includes:

- CYP not registered with a GP within the geographical boundaries
- Staffordshire Moorlands
- Stoke on Trent
- Stafford's and Surrounds
- Seisdon Peninsula
- Cannock Chase
- CYP where the service does not have an active duty of care
- CYP receiving packages of care by other providers that conflict with evidence-based interventions delivered by the physiotherapy service
- CYP for whom respiratory difficulties are the presenting problem will remain under the care of secondary and acute services
- CYP with Chronic fatigue / Pain syndrome and Functional Neurological Disorder (FND) where there is a need for psychological input

3.12 Interdependence with other Services/Providers

The community physiotherapy service will operate with many partners including:

- Children and young people
- Parents and carers
- Education providers
- Health Visitors
- School Nurses
- Special School Nurses
- GPs
- Staffordshire County Council
- Stoke on Trent City Council
- Community Paediatricians
- Consultants – Acute and Community
- SEND teams
- Staffordshire Safeguarding team
- Voluntary/third sector
- CAMHS
- Equipment services
- Community Childrens Nursing team
- Other Allied Health Professional Services

3.13 Safeguarding

Work in line with current safeguarding policies and procedures as detailed by the local safeguarding board & national guidance (Working together to Safeguard Children 2018):

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/>

3.14 Special Educational Needs and Disabilities (SEND)

The service will take into consideration and respond to any requirements as part of the SEND Guidance:

<https://www.gov.uk/government/publications/send-code-of-practice-0-to-25> relevant to their role.

The Service will provide advice and support children and young people, their parents and carers regarding arrangements for the assessment and provision of SEND. Special Educational Needs (SEND) legislation requires that the needs of children and young people with Special Educational Needs should be considered up to age 25, in some cases older young people will remain in a special school setting beyond their peers in mainstream schools.

	The Service will ensure that relevant information is included in the Staffordshire Local Offer including transition arrangements and that this information is kept up to date: https://www.staffordshireconnects.info/kb5/staffordshire/directory/localoffer.page <u>3.15 Personal Healthcare Budgets</u> Following the mandate from NHS England regarding the provision of Personal Healthcare Budgets (PHBs) for individuals who may benefit from this offer, where possible the service will support CYP and their family and carers who wish to pursue a personal healthcare budget. If a PHB is requested by the CYP and family/carer the service will support and assist their decision making and pursuit of alternative treatment where possible in conjunction with CCGs. Providers will collaborate with CCGs to provide an option of a PHB. This should be done at a scale and pace that meets local need and resources. PHBs can be offered in several ways, either as a notional budget, third party or direct payment or as a combination of all three. <u>3.16 Applicable National Standards e.g., NICE</u> Applicable Standards set out in Guidance and/or Issued by a Competent Body eg Royal Colleges <u>3.16 Applicable Local Standards</u> Primary, secondary and community services should continue to work closely together and meet regularly to review clinical practice and share best practice initiatives. The service will contribute to the outcomes identified within the collaborative partnership of the Staffordshire Children, Young people and families Strategy 2016-2026: • Starting well • Growing well • Living Well • Happy and healthy • Safe and belongs • Achieves and contributes <u>3.17 Applicable Quality Requirements (See Schedule 4 Parts A-D)</u> <u>3.18 Applicable CQUIN Goals (See Schedule 4 Part E)</u>

Service Name	D2A Pathway 1 Recovery, Rehabilitation and Reablement
Service Specification Number	CS_55
Service aims and desired outcomes	
A need-led service that will increase the focus upon promoting independence and improving outcomes for individuals and move away from disease/ condition-based pathways through an integrated model of care following the principles of recovery, rehabilitation and reablement (RRR) whilst also supporting the NHS Long Term Plan and Staffordshire County Council and Stoke on Trent City Councils Corporate Plans. The service aims to: • Support more people to stay safely at home during sub-acute illness/crisis • Increase the percentage of people supported in their own home to ensure timely discharge or to avoid admission to an acute hospital setting. • Ensure people and their families/carers are actively engaged in the setting of their goals for recovery as part of their care plan • Support the reduction of unrequired acute and sub-acute hospital admissions • Support the reduction in longer care needs as individuals recover independence through supportive interventions. • Support the reduction in the number of transitions in care and reduced unnecessary movement around the system • Support the reduction in numbers of re-admissions within 30, 60 and 91 days post discharge. • Support the reduction in healthcare acquired functional decline through timely discharge • Improve reported experience of the pathway • Support the reduction in admissions to long term care or level of care required • Always promote Home First as being the appropriate pathway where needs can be met at home • Improve quality of life and functional ability • Support preventative solutions, thus reducing the long term cost of health and social care e.g. through the increased use of Assistive Technologies (AT) • Raise awareness and understanding of the benefits of AT to help people self-care • Ensure the principles of Recovery, Rehabilitation and Reablement are embedded in care pathways to increase independence, reduce dependency on services and 'delay' the need for care • Contribute to Better Care Fund outcomes namely effectiveness of reablement, prevent unnecessary emergency admissions and readmissions and prevent/reduce premature admissions to residential and nursing care. • Contribute to the ambition of increasing the percentage of people leaving hospital through pathway 1.	
Service description / pathway and location(s) from which it will be delivered	
<i>"Under the Discharge to assess, home first approach to hospital discharge, the vast majority of people are expected to go home (to their usual place of residence) following discharge. The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs." (Hospital discharge and community support guidance - GOV.UK (www.gov.uk))</i> The 'Discharge to Assess' (D2A) model focuses on people who are clinically optimised and no longer require an acute hospital bed but may need initial support to go home to continue their recovery, rehabilitation and reablement interventions. People are discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs, where required, can then be undertaken in the most appropriate setting and at the right time for the person. The model aims to ensure speedy discharge from hospital with home being the first option for the majority of people. Pathway 1 – Recovery, Rehabilitation and Reablement at home (RRR) People are discharged home with support and therapy provided by the service in order to support recovery to independence. On completion of their pathway 1 intervention people will end with no ongoing services or be referred by the service to the most appropriate pathway at the time of discharge. According to the outcome of the appropriate assessment and treatment this could be core	

commissioned services (e.g. District Nursing), self-funded care, local authority funded or continuing healthcare.

Pathway 1 teams will deliver targeted and focused interventions and support that are underpinned by dynamic strength/asset based person centric goals and objectives to optimise personal independence based around 'what matters to me', enabling the person to 'live the life I want to live'. The Pathway 1 interventions are delivered by multi-disciplinary teams with expertise from across health and social care, are free at the point of use and are a time limited (maximum 6 weeks) intervention, with a clear start and planned end date, on average lasting 2-3 weeks or until the person is optimised. There should be a co-produced individualised plan that will include, where necessary provision for a Care Act Assessment to identify any ongoing care and support needs running parallel to the intervention and where appropriate other relevant clinical assessments.

"People will have a structured person centered recovery, rehabilitation and reablement support plan that they have contributed and agreed to. This will be tailored to their individual needs and involve active therapy, treatment or opportunity for recovery and clearly defined goals, as well as a realistic expected date of discharge. This shall be developed in collaboration with the person and will take into account theirs and their relatives'/ advocates preferences and wishes. The support plan should include standard components of the Comprehensive Model of Personalised Care as follows:

- Shared decision making
- Personalised care and support planning
- Enabling choice
- Social prescribing and community based support
- Supported self-management

The Pathway 1 service is a **Recovery Rehabilitation and Reablement** service underpinned by the following 5 principles and the key principles to help reshape rehabilitation, reablement and recovery services (working group coordinated by The Midlands Discharge Cell):

1. We will always think "Home First"

This means supporting the person to remain or return to their usual place of residence as soon as possible, reflecting a person-centered approach. It should be applied both at the point of any decision to admit as part of a local urgent care offer, and as part of person-centered discharge planning which focuses on 'what matters to me' rather than 'what is the matter with me' and plays to my strengths as an independent person.

"Home First" means reinforcing a common purpose across the local health and care system, including the extended primary care team, to the attainment of optimal outcomes and wellbeing for all people with a rehabilitation/reablement/recovery need. This also includes working alongside family and voluntary services to support and reable individuals.

2. We will always work to optimise a person's potential for recovery, rehabilitation and reablement before we undertake an assessment for their long term care needs

This means that across the Health and Care System we will assume that any loss of independence will have a reversible element, be that complete or partial, until it is proven that a period of rehabilitation/reablement/recovery, including consideration of adaptations and use of technology, is unable to reverse.

3. "There will be no wrong door to accessing the right care, at the right time in the right place"

This means a 'system' approach to care and active avoidance of organisational silo working, with a focus on facilitating and enabling access to the right care, at the right time in the right place.

This means that there is a responsibility on all organisations, services, teams and individuals to align to a common purpose that is not constrained by organisational boundaries.

This means a commitment to standardisation across services governed by simple rules for access to the right care to support rehabilitation, reablement and recovery.

4. "We will measure what matters"

This means Health and Care Systems will have a core set of metrics that focus on outcomes of RRR services utilising standardised tools which **could include:**

- Functional improvement - Barthel Index (as a minimum on entering the RRR service and on departing)
- Proportion of people achieving 'independence' with no new or with reduced prior domiciliary care and support on completion of RRR – ASCOF 2D
- People receiving reduced input to maintain independence at the end of the pathway than on entry
- Proportion of people remaining at home 91 days after commencing RRR - ASCOF 2B(1)
- Improved experience (D2A Survey)

Health and Care Systems will have a core set of metrics that focus on operational quality and effectiveness of RRR services, which should include:

- Access/Timeliness - waiting times,
- Equity of access – data by age, geography, care setting, socio-demographic characteristics etc. Equality is not about treating everyone the same; it is about ensuring that access to the service is available based on the assessed need of an individual (not diagnosis) whilst taking account of people's differing needs and capabilities.
- Efficiency and Safety e.g. inappropriate readmission to hospital and monitoring of the 'wastes of rehabilitation/reablement/recovery services capacity

Specific reporting metrics and quality and performance KPIs will be included within the reporting schedule

5. “We will enable and support all colleagues to develop and work collaboratively”

This means Health and Care Systems actively recognise the key role of leaders who work across organisational boundaries at all levels, with the aim of eliminating the risk of silo working. There will be a collaborative developmental programme recognising the importance of enabling all staff to work to the top of their competencies.

It is acknowledged that people will recover at differing rates. The Pathway 1 service will be provided for up to a maximum of 6 weeks. During this time they will receive the services they need to continue their recovery and will also be assessed, for any longer term health and social care needs

Pathway 1 teams will also support step up referrals onto the service to support people to remain at home where ever possible including those that would benefit from short term recovery, rehabilitation and reablement and support the system ambition of preventing inappropriate admissions to acute hospital care where possible.

Pathway Delivery and locations

The Pathway 1 Service will operate across the whole of Staffordshire and Stoke on Trent and be split into the 8 teams that will work flexibly across 3 geographical areas to respond to the demands for the service. The service offer across the whole of Staffordshire and Stoke on Trent will be consistent and equitable regardless of where the person lives, and which team is providing the intervention.

These 8 teams split into 3 locations will be

Stoke, Newcastle, Moorlands (North Staffordshire and Stoke On Trent)

East Staffs and Burntwood, Lichfield and Tamworth (South East Staffordshire)

Stafford, Cannock and Seisdon (South West Staffordshire).

We will also subcontract Pathway 1 activity to our agency framework of subcontracted providers where required to support increased levels of demand in some areas, surges in activity and as part of our BCP with a longer term commitment to reduce agency use to a maximum of 30% following successful in house recruitment. MPFT will continue to provide the required wrap around to people where their RRR intervention is delivered by one of our agency providers and also provide the case management for all service users.

The service will operate on an integrated leadership and interdisciplinary approach and place the person at the center of the service we provide.

People will have a structured person centered recovery, rehabilitation and reablement plan that they have contributed and agreed to. This will be tailored to their individual needs and involve active therapy, treatment or opportunity for recovery with clearly defined goals, as well as a realistic expected date of discharge. This will be developed with the person and will take into account theirs and their relatives' / advocates preferences and wishes with a clear focus on “I and we” statements.

Each person on the pathway will have a lead worker assigned to oversee their care, ensuring a process of regular review.

Clinical and Medical Governance

Clinical and medical governance will be provided for Pathway 1 Hospital discharges by MPFT and the wider UCCC and CRIS pathways and will not involve their registered GP (unless they are already involved) until they are discharged from the service as detailed below.

See appendix document for Clinical escalation pyramid

Pathway 1

Primary Care (GPs) shall retain governance for **step up people** referred into Pathway 1

Primary Care (GPs) will retain clinical responsibility for step down people that are on the caseload **but not in receipt of any direct clinical or therapy services/ input or intervention from the service**. I.e. the clinical needs of the individual are unchanged prior to the episode of ill health and they are only in receipt of non-clinical RRR.

Primary Care (GPs) shall also retain clinical responsibility for people under Provider of Last Resort (POLR) as transition to long term maintenance/ domiciliary care. I.e. the individual has completed a period of recovery, rehabilitation and reablement and has received a statutory social care assessment for ongoing care needs. This has been accepted by the Local Authority and the Provider is providing care hours until the long term domiciliary package of care can be sourced. **(left in this specification for the case by exception where a person remains with pathway 1 longer than the agreed transition period)**

Operational hours

- Referrals into the service following hospital discharge will be via the Track and Triage teams which operates 7 days a week between the hours of 8-8.
- Step up referrals from the community (Social care, First Contact, UCCC, CRIS, GP, CIS, RR) will go direct to the Pathway 1 Teams.
- The Pathway 1 service is provided 365 days a year and operates between the hours of 7am – 10pm

Any acceptance and exclusion criteria and thresholds

Acceptance

- Over 18 years of age and sub-acute needs
- People who may benefit from recovery, rehabilitation and reablement to remain independent at home
- People with sub-acute health needs that do not need an acute admission.
- People with complex health needs that may be eligible for Continuing Health Care (CHC) funding to meet their needs
- People that may benefit from short term interventions to increase their independence linked to either health or social care needs or both
- People that may require assessment for long term care and support needs following a period of RRR
- People identified as 'end of life' will be supported if they have an urgent need for short term health or social care (Bridging service – PCCC to continue to source required support)
- People with needs that require a level of intervention (either in terms of frequency, intensity or complexity) that cannot be met by core services with the overall goal being to prevent admission (to hospital or long term care) or facilitate safe discharge.
- People identified as appropriate by the track and triage team in line with locally agreed arrangements / protocols and discussion across our collective leadership team within track and triage.
- People directly referred from emergency portals, for example where people present in a crisis with needs that can be safely managed in the community
- People directly identified from Mental Health or Learning Disability services where a short term physical health need has been identified.
- Residents in care homes (nursing and residential) a diagnosis of dementia (primary or secondary diagnosis) and coexisting physical health and / or social needs
- People who agree to participate and work towards set RRR support plan and goals
- People being discharged on specific pathways such as the orthopaedic pathway

Exclusions

- Under 18 years of age
- Adults identified as having acute/unstable needs which cannot be managed within a community setting

- Discharges that can be supported via more appropriate services e.g. Stroke – Early Supported Discharge, social care respite pathways
- People who require longer term interventions and rehabilitation e.g. slow stream rehabilitation
- People with needs that can be managed by commissioned core services.
- People that require specialist inpatient rehabilitation such as stroke and neuro rehabilitation
- People in **an acute phase** of functional mental illness (e.g. acute psychosis, acute depressive episode, functional psychiatric disorders) with no other support needs for ADLs. Close links to existing mental health services/ professionals will be required for those people with complex multiple needs
- People not medically manageable in a community setting or where environmental issues prevent safe management of healthcare needs
- Maternity and paediatric patients
- People where the primary issue is carer breakdown and therefore require respite
- People who are listed with broker prior to hospital admission and their assessed needs remain unchanged
- People with housing issues with no rehabilitation and reablement goals
- People with self-neglect where there is no reablement or rehabilitation goals
- People who have already had multiple complete cycles of the services within D2A pathways determined by and MDT approach

Pathway interdependencies

Core Community Services

Social Care pathways

UCCC

CRIS

PCCC

VW

The service will work across the ICS to proactively adopt alternative approaches to the delivery of care through the use of assistive technology as appropriate.

Population / geography to be covered

People who are a resident within Staffordshire and Stoke on Trent and/or are registered with a GP within Staffordshire and Stoke-on-Trent

Drivers for Change (TM added for context – wasn't in spec template)

[Managing Transfers of Care](#)

[Reducing Preventable Admissions to Hospital and Long-term Care](#)

[Developing a Capacity and Demand Model for Out of Hospital Care, Professor John Bolton](#)

[Implementing the Home First Discharge Policy Top Tips](#)

[People First, Manage What Matters](#)

[Implementing a Collaborative Commissioning Approach to](#)

[Home First](#)

[Discharge to assess, home first](#)

[Hospital discharge and community support guidance - GOV.UK \(www.gov.uk\)](#)

Service Specification No.	MH_01															
Service Specification Reference	MH_01															
Service	Community Children’s Nursing (CCN)															
Commissioner Lead	Simon Runnett															
Provider Lead	Alison Totty															
Period	1 st April 2022 to 31 st March 2023															
Date of Review	By 31 st March 2023															
1. Population Needs																
1.5 National/local context and evidence base Children and young people account for 22.4% of the overall population of Stafford and Surrounds, Cannock Chase and East Staffordshire CCG areas. Many will access health care for an illness or injury at some point during their childhood, with the greatest activity being for pre-school children. Most illnesses can be cared for in the home if appropriate primary care support services are made available. Children’s Community Nurses are able to facilitate this by providing safe and sustainable services for children, young people and their families for short term illnesses, long term conditions/disability and end of life care. The service will: • Provide care closer to home • Support and strengthen existing primary care teams and in the management of sick children in the community • Support reduction in: ○ the number of hospital admissions ○ length of in-patient stay ○ hospital attendances • Support children who are dying to do so within their own home (where this is possible / appropriate) • Provide a seamless transition between acute and primary care • Facilitate self-care within families • Support eligible children, young people and families in pursuing personal health budgets if desired.																
2. Outcomes																
2.1 <u>NHS Outcomes Framework Domains & Indicators</u> <table><tr><td>Domain 1</td><td>Preventing people from dying prematurely</td><td>X</td></tr><tr><td>Domain 2</td><td>Enhancing quality of life for people with long-term conditions</td><td>X</td></tr><tr><td>Domain 3</td><td>Helping people to recover from episodes of ill-health or following injury</td><td>X</td></tr><tr><td>Domain 4</td><td>Ensuring people have a positive experience of care</td><td>X</td></tr><tr><td>Domain 5</td><td>Treating and caring for people in safe environment and protecting them from avoidable harm</td><td>X</td></tr></table>		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
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 • Children and young people cared for safely in the most appropriate location • Seamless transition between acute and primary care • Reduction in admission and re-admission to hospital • Earlier discharge from hospital, if care can be offered in the home																

- Where they wish to do so, children are provided with end of life care to enable them to die at home
- Improved patient & parent/carer satisfaction
- Parents feel supported and empowered to care for their children at home
- Children and young people are supported in developing self-care abilities
- Effective transition to adult services is supported.

3. Scope

3.1 Aims and objectives of service

To work in an integrated way with acute hospitals and community provision across health and social care to:

- provide care closer to home
- safely prevent or shorten the length of stay in hospital for children with acute illness by allowing them to be cared for at home until they get better
- avoid unnecessary admissions and attendance at hospitals
- enable children and young people with ambulatory care conditions, additional or special needs, and/or palliative care needs to have access to appropriate services in the community
- provide early identification of serious health needs in children and young people who are referred, offering appropriate advice and support and referral onwards as required including arrangement of direct admission for children when required
- work in partnership with children and their families, and partner agencies
- work closely with commissioners of services to develop new services and develop services in line with national and local priorities, consultation with service users and guidance
- Encourage children and young people to gain control of their care including guidance regarding personal budget options for the delivery of health care services

3.2 Service description/care pathway

The service will work in a variety of community settings, primarily in the home environment, however flexibility is required as it may be necessary to visit schools or provide support in general practice, community clinics, short break venues and hospitals.

Practitioners will work as part of multi-agency teams to agreed integrated care pathways across acute and primary care. As integrated teams develop the service will be expected to work within the agreed framework.

Services to be available to all children and young people, irrespective of disability, ethnicity or sexuality, who meet the criteria for referral. It will aim to:

- Work in an integrated way with other health and care agencies to avoid unnecessary admissions and attendance at acute facilities
- Facilitate early discharge from hospital
- Provide community children's nursing service for children/young people in their own homes and other appropriate community settings
- Develop professional partnership ensuring the provision of a seamless service for children/young people and their families
- Participate in discharge planning and facilitate early discharge from hospital
- Planning, implementing, monitoring and evaluating programmes of care
- Provide specialist health advice and support to children/young people, parents/carers, giving them the knowledge and skills to care for their child at home
- Promote and support self-care
- Provision of nursing interventions and where necessary training to support the child within the home environment.
- Ensure each child/young person has a robust care plan which is developed with the family
- Monitor the provision of supplies and equipment necessary for continuing care when Community Children's Nursing is the prime agency involved.

- Engage with client group and work to 'Hear by Right' Standard. Utilise engagement to steer service development
- To work with and develop new clinical and multi-agency pathways, including integrated care pathways
- Offer a paediatric phlebotomy clinic for GP requests in Stafford and Cannock.
- To work with CCGs to provide specialist clinics according to local need e.g. phlebotomy, chronic constipation, eczema (For Development Plan)
- To work with commissioners in the developmental programmes aimed at extending the effectiveness and cohesiveness of local health and social care provision.
- Participate in the revised arrangements for special educational needs including provision of health assessment reports within the timescales prescribed by the SEN Code of Practice (2014)
- Encourage and advise carers, children and young people in accessing personal budget options as a means of providing health and social care.
- To participate in all relevant multi-disciplinary care systems that provide support and oversight of a child/young person's care.

Response times

- Service will respond within three hours (telephone call or face to face) to a referral for a child/young person with an acute illness.
- Service will respond within 2 working days to a referral for a child/young person with a non-acute condition (telephone call or face to face)
- Time of visit will be negotiated with family
- Notification of an attempt to call will be left with the family if they are not in when the nurse visits
- Ensure parents have clear contact points for accessing support – 24 hours a day. This might include Acute Services or NHS out of hour's provision.

Care Planning

- Plan of care to be agreed with the child/young person, parent/carer and multi-agency partners (where necessary) who are involved with the family.
- Discharge letters to be sent to General Practitioner and parent/carer (and other healthcare professionals as appropriate).
- Manage case-loads and coordinate care, discharging and referring patients as appropriate and in line with agreed pathways of care
- Assessment and care plans for children with long term conditions developed in partnership with family and partners, for all children who are referred to the service.
- Agree clear management plan based on evidence and informed by protocols, guidelines and pathways
- Attend discharge planning for children going home from hospital with complex medical needs
- Key worker for children with complex/palliative care needs, where most appropriate.

Clinical Delivery

- To take blood specimens from babies (under 12 months) who have missed the new born bloodspot screening test usually undertaken within Acute Maternity Services
- Implement packages of care from acute/specialist regional centres which fit referral criteria e.g.
 - Administration of cytotoxic therapy
 - Acute respiratory illness
 - Phlebotomy
 - Home oxygen
 - Administration of Intravenous Antibiotics (subject to service capacity)
 - Wound Care
 - Post-surgical support (where nursing support is required)
 - Care of Central Venous lines
 - Support for children receiving enteral feeding
 - Care of children receiving oncology treatment

- Palliative and End of life care
- Dermatology
- Constipation
- Acute eczema

Exclusions: Children with rare, highly specialised clinical needs, such as home dialysis or home ventilation. These children will require care from services outside that provided by CCN Team; however these services may be commissioned from the CCN team through continuing care provided the team have the relevant expertise and supervision.

- To act as lead professional/key worker as appropriate
- To support and develop decision making tools
- Participate in shared care with hospital and with General Practice
- Promote and support self-care
- Assessment and management of pressure areas at home
- Monitor and ensure appropriate pain control throughout assessment and intervention
- Ensure parents have clear contact points for accessing support
- To work with and development new clinical and multi-agency pathways, including integrated care pathways
- Support and contribute to SEN assessment and care management approach.
- Support Continuing Care team in the assessment of needs for funding requests. Complete appropriate section of the Decision Support Tool (DST) for children with continuing care needs.

Safeguarding

- To work to National and local Staffordshire Locality Safeguarding Children's Board (LSCB) policies, procedures and guidance and to national guidance.

Palliative care/end of life care

- Agree and support a plan for end of life care
- Facilitate maintenance of the child in the home environment and to provide end of life care for children/young people within the home environment, wherever possible.
- Involvement in pain management and symptom control
- Liaise with other services/professionals as required
- Access continuing care funding to provider 24 hour support, as required. Following Continuing Care funding protocols, as appropriate

Transition:

- Facilitation of transition from paediatric services to adult services, with a particular focus on children with long term conditions, disability or who have life limiting conditions.
- To develop interagency transition pathways with other partner agencies and to work to interagency pathways as they are developed in Staffordshire.
- Unmet needs forms to be completed where a service is not available in the transition to adulthood
- Protocols to take into account the maturity of the young person and allow for flexibility and scope for choice
- Protocols to take account of policies and guidance from Staffordshire Local Children's Safeguarding Board (LSCB) and vulnerable adults policy
- Protocol to be agreed by commissioners
- Transition planned to commence on referral or at least 6 months prior to transition, where transition is clinically indicated and services are commissioned, however it is reasonable to assume it may commence earlier with more long-term conditions.

Special Educational Needs

- To advise and support children, young people and their carers regarding the revised arrangements for the assessment and provision of SEN support
- To provide assessments required by the EHC planning process within the required timescales.

- To participate in assessment and planning for a as part of the EHC process.
- To encourage and support relevant children and young people in accessing SEN based health care via the personal health budget route.

Continuing Care (Children, Young People and Adults)

- To provide information for children and young people known to the service as part of the continuing care assessment process for children and young people including advice and support for those transitioning from children and young people arrangements to adult continuing care services.
- To encourage appropriate children and young people to access personal health budgets within the provision of continuing care.

Training (external):

- To provide or support training for families and staff from partner agencies on caring for children with specific nursing needs who are currently known to the service.
- The service will provide additional training for partner agencies for cases not the caseload, where it is funded by the partner agency.

Consultation and Service User Engagement

- Adopt 'Hear by Right' and 'You're Welcome' Standards
- Develop a range of methods for engaging children and young people to obtain their views on services-at both micro & macro levels.

Training (Internal and Staff Development)

All staff should receive regular supervision, of at least one hour per month. This can be received through a combination of group and individual supervision sessions. Supervision should be aligned to acute pediatric nursing services and where possible training should be across community and acute services.

They must ensure they meet their CPD requirements

All staff shall be required to undertake all mandatory training requirements-including safeguarding, equality and diversity.

All staff will receive appropriate up to date training to enable them to utilise all equipment appropriately.

The service will include nurse prescribers and aim to develop Advanced Nurse Practitioners and nurses with specialist qualifications in specific areas e.g. palliative care, therefore adapting and developing the service to meet local needs and the local delivery plan.

The provider must ensure that the workforce is able to meet the needs of the service.

3.3 Referral criteria & sources

Referrals will be accepted from the following:

- General Practice
- Out of Hours service
- District Hospitals
- Regional Hospitals
- Hospices
- Short term break service for training and supervision
- Other healthcare professionals where the child/young person has a nursing need
- Self-referral with prior agreement from the service

3.4 Referral Criteria

- The child/young person must have a specific nursing need that requires a children's trained nurses which is not usually provided by General Practice, Health Visitor or School Nurse because of the expertise required or the timescales in which the child/young person can be seen.
- For any new period of acute illness the child/young person will need to have been assessed by a medical practitioner before the referral can be accepted
- Child/young person who have an acute but non serious illness that is likely to be self-limiting and who require nursing support and monitoring of their condition. This support to be in the home or by phone

- Child/young person who requires investigative procedure i.e.
 - Phlebotomy
 - Urinalysis
 - Blood pressure monitoring
 - Swabs
- Child/young person/families who require education and teaching regarding a specific medical condition, i.e.
 - Acute Constipation
 - Acute Eczema
 - Enteral feeding
- *NB this list is not exclusive and other conditions/needs could be accommodated in line with agreed service competency levels*
- Children/young people who require complex wound care
- Children/young people who require specific injections/intravenous drug administration
- Children/young people who are oxygen dependent
 - Support continuing care team in development of a care package
 - 24 hour overnight studies at home
 - Coordinate change in oxygen regimes and facilitate family holidays
- Children/young people who require end of life care.
- Children/young people who require specialist support for a package of care on discharge from acute or specialist centres
- Children and young people who are in receipt of short term breaks who require any of the above
- Neonatal Blood spots where this has not been completed prior to discharge from hospital

Referrals that do not meet the referral criteria will be recorded and redirected to the most appropriate service

3.5 Exclusion criteria

Young people age 16-18 years will be managed through Community Children's Nursing Services, unless services are being provided by a more appropriate service, this will be reliant upon the young person's preference and which service is deemed most appropriate

If a person is residing temporarily within the area, but are registered with a GP elsewhere (i.e., student or child placed in the area by another authority) host CCG will be responsible for payment under the Responsible Commissioner guidance

The service will not provide the following care, but will liaise with the referring agencies to facilitate access to the most appropriate provision:

- Children and young people with an unstable medical condition
- Children and young people who require emergency care/urgent medical attention
- Children with long term ventilation
- Administration of routine oral medication
- Assessment for social care needs
- Children requiring injectable medication that is not on the agreed Trust formulary.

3.6 Response time & detail and prioritisation

Service will respond within three hours to a referral for a child/young person with an acute illness.

Service will respond within 2 working days to a referral for a child/young person with a non-acute condition

3.7 Hours of Operation

Stafford and Surrounds and Cannock Chase - 7 days per week, 9:00 – 22:00 and 9:00 – 17:00 on Public Holidays

Burton – 7 days per week, 9:00 – 17:00

3.8 Discharge Planning

Discharge plans to be completed in conjunction with partner organisations and in partnership with the child/young person, parent/carer and multi-agency partners who are involved with the family.

Children and Young People will be discharged from the CCN Service when:

- They no longer require the service – condition has improved
- Care has been transferred to another provider i.e. acute unit
- General Practitioner and referrer will be notified of discharge within 72 hours
- Non-attendance at a clinic x 2 will result in discharge, however if there are concerns regarding the clients condition the referrer will be notified prior to discharge. If there are safeguarding concerns, Child Protection policy will be followed in line with Staffordshire LSCB and National guidance

Discharge letters to be sent to General Practitioner and referrer and parent/carer

Service will seek to educate and empower children/young people and their carers to have a greater understanding of the condition and to be able to manage it.

To provide supporting literature to enable this and document competency of families for more complex procedures

Information will be provided in a variety of formats, language, big print, pictorial, audio etc.

3.9 Population covered

The service covers all children and young people who live in East Staffordshire, Cannock Chase and Stafford and Surrounds CCG areas, and who are registered with a General Practice from those CCG's, for children between the ages of 0 -18 years of age.

3.10 Any acceptance and exclusion criteria and thresholds

All referrals must be for children aged between 0 – 18 years of age that have a clinical nursing need. All referrals will be considered and those who are not appropriate will be referred on to the appropriate service or where this is not possible, referred back to the referrer.

- The service is open to children with a nursing need
- Children with an exacerbation of their long term condition
- Children who are at risk of hospital admission

3.11 Interdependence with other services/providers

The service will work collaboratively with all those listed below and any other provider or agency involved in the care of the child/young person as required. They will work proactively and collaboratively with these agencies to develop robust pathways of care and provide a holistic service.

- Parents and families
- Other carers
- General Practice
- Acute hospitals including regional and national centres
- CAMHS
- Learning disability services
- Special School Nursing
- School Nursing
- Health Visiting
- Physiotherapy
- ASD (assessment and intervention) Service Providers
- Occupational Therapy
- Dietetics
- Community Paediatric Services
- CIT
- SALT
- Equipment Services
- Adult services

- Hospices
- Health and Social Care
- Families First
- Third Sector
- Education providers

4. Applicable Service Standards

The service must ensure that they contribute to the wider patient safety agenda including as is appropriate, but not exclusively, the control of infection agenda (for example, training, audits and root cause analysis investigation of C.diff and MRSA SUIs), and the identification, reporting and investigation of incidents and complaints. Participation in clinical audit and implementation of changes arising from audits should take place as a minimum, annually, in accordance with the organisation's audit plan. The service should be able to demonstrate learning and improvement across the quality agenda and in response to local and/or national policy guidance

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years. Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Safeguarding

The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

As appropriate adult safeguarding procedures should be adhered to in all cases.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:

https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

4.1 Applicable national standards (eg NICE)

All service and advice provided should comply with the following key legislation and guidance:

- Relevant NICE guidelines
- Relevant NPSA and MHRA safety guidance / alerts
- Association for Children with Life-Threatening or Terminal Conditions and their families, ACT (2004)
- Health lives, brighter futures – The Strategy for children and young people's health, DH / DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services. Transition: getting it right for young people DH (2006)
- The National Service Framework for Long-term Conditions, DH (2005)
- Commissioning Children and Young Peoples Palliative Care Services, DH (2005)
- NSF for Children, Young People and Maternity Services. Disabled Children and Young, DH (2004)
- People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- DH (2003) Getting it right: National Service Framework for Children. Standard for Hospital Services.
- NHS at Home: community children's nursing services (DH, 2011)
- Working Together 2013
- Children's Act (2004)
- The NMC Standards and Code of Conduct
- RCN Children's Community Nursing Promoting Effective team working for children and their families (2003)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)

The above is not an exhaustive list of legislation & guidance and the provider would be expected to keep up to date with all relevant legislation, guidance and NICE guidance.

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

As above

4.3 Applicable local standards

All Trust procedures, policies and practices.

5. Applicable quality requirements and CQUIN goals

5.12 Applicable Quality Requirements (See Schedule 4A-C)

5.13 Applicable CQUIN goals (See Schedule 4D)

Equality Requirements – General Responsibilities of Service

- The service will be delivered in compliance with the Equality Act 2010, the Human Rights Act 1998; and the principles, rights and pledges set out in the NHS Constitution
- The service provider will be required to regularly report to the commissioning organisation on operational evidence to provide assurance that services are compliant with s149 (1) of the Equality Act 2010 – the Public Sector Equality Duty

6. Location of Provider Premises

The Provider's Premises are located at:

Community settings, including home, schools, clinics, hospitals and General Practice

7. Individual Service User Placement

N/A

Service Specification No.	MH_02
Service	Specialist Services – Neuropsychology for Adults
Commissioner Lead	Simon Runnett
Provider Lead	Karen Hopley
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.6 National/local context and evidence base

Clinical Neuropsychologists apply a scientific understanding of how brain dysfunction affects thinking, memory, emotions and behaviour. They carry out specialist assessments of these functions in order to understand exactly what difficulties the person is having, or is likely to have, and to monitor any changes. They advise on the most likely outcome of such neurological conditions, and on how best to cope with any resulting long term difficulties, both for the individual and their family.

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

- NICE Guidelines: Brain Injury; Epilepsy; Neurological Conditions; Strokes; Brain Tumours.
- NSF for Long-term (Neurological) Conditions

This specialist service is commissioned by a number of local Primary Care Trust's within Staffordshire to ensure local provision for local patients.

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

The following health gains are likely to result from applying psychological interventions with individuals, their family, and the wider organisational system of health or social care:

- Prevention of severe and enduring mental health problems.
- Improvements in the quality of life for people with brain injury and/or neurological conditions.
- Reduction of stress and increased coping ability in carers.
- Acquisition of new skills and coping strategies.
- Improved planning and co-ordination of psychological treatments and services for people with brain injury and/or neurological conditions.

- A reduction in the severity/frequency of problem behaviours, leading to a reduction of inappropriate admissions to hospital, and out-of-area referrals.
- A reduction in the use of psychotropic medication.
- Return to education / employment
- Reduction in requirements for care / benefits

3. Scope

3.1 Aims and objectives of service

The Clinical Neuropsychology service is principally intended to provide detailed assessments with the aim of measuring the extent and nature of cognitive deficits and mood disorders, as well as monitoring change in these areas, following (confirmed or suspected) neurological injury or disease.

This specialist service provides treatment using a 'bio psychosocial' model which is evidence based. The treatment aims to optimise an individual's functioning within a social context with a view to increasing independence, quality of life, and facilitating return to work, where appropriate.

The service uses evidence-based psycho-diagnostic assessments in an attempt to gauge the impact of neurological injury or disease (i.e. Multiple Sclerosis (MS), Parkinson's Disease, Huntington's, Disease, Motor Neuron Disease, brain tumours, Traumatic Brain Injury etc.) on cognitive, behavioural and social functioning, in addition to mood/psychiatric status.

This Clinical Neuropsychology service objectives are to:

- Provide formulations and diagnosis as appropriate, for outpatient and inpatients across the South Staffordshire region.
- Provide psychological interventions and/or the development of rehabilitation programmes, including psychological therapy using a range of approaches including behavioural, cognitive, and systemic therapies.
- Provide Neuropsychological support and education for carers and families.
- Contribute to the development of high quality services and the evaluation of their effectiveness.
- Lead responsibility for liaison with voluntary agencies.
- Teaching and training for other professionals within the multidisciplinary team.
- Psychological advice and consultation on service developments.

3.2 Service description/care pathway

The service is able to provide neuropsychological assessments and treatment/rehabilitation for adults, both male and female, from the age of 16 years. The vast majority of referrals are considered to experience a degree of impaired cognitive, behavioural or emotional functioning following a confirmed or suspected neurological injury or disease. These may include, but are not limited to:

- Acquired brain injuries, including traumatic brain injury, cerebral infections, hypoxic brain injury, strokes and tumours
- Progressive brain injuries, e.g. MS, Parkinson's Disease, Huntington's Disease, Motor Neuron Disease
- Epilepsy (seizure disorders)
- Congenital or birth injuries
- Individuals with suspected neurological impairment, e.g. those presenting with memory concerns

We currently offer detailed assessments to all individuals who are recently diagnosed with MS, in order that the progress of cognitive deficits or mood problems can be monitored throughout the course of their illness. This will be co-ordinated through the MS and MND Specialist Nurse.

The core service provides neuropsychological assessments and treatment/rehabilitation to people with possible cognitive and/or emotional deficits following suspected or confirmed neurological injury or disease.

The majority of patients will require a minimum of three contacts:

- 1) 60 – 90 minute initial clinical assessment;
- 2) 180 – 240 minute detailed Neuropsychology assessment;
- 3) 60 – 90 minute feedback meeting with patient and/or carer(s).

Assessment

A detailed Neuropsychological assessment investigates brain-behaviour interactions from a bio-psycho-social perspective. It examines the relative influence of medical, social, educational history and acquired brain injury and/or neurological condition on current and future functioning.

The service provides individualised, comprehensive neuropsychological assessments using standardised tests and procedures. This includes assessments of various cognitive functions, including:

- Planning, organisation, and problem-solving
- Attention, memory and learning
- Perceptual and motor abilities
- The differing components of intellectual functioning
- Emotional adjustment and behaviour
- Additional assessments may also include personality functioning, assessments of Capacity, differential diagnosis, etc.

Formulation

Initial assessments are used to generate a clinical case formulation. This is a theoretically-based explanation or conceptualisation of a person's difficulties based on the information obtained from a Neuropsychological assessment. A formulation contains hypotheses about the cause and nature of presenting problems. Formulations are used to devise the most appropriate treatment approach and can be shared with service users, staff teams and/or family members as appropriate.

Care Planning

Programmes are based on a plan of care devised in collaboration with the patient and their carers. Associated professionals are informed of their care plan and invited to collaborate as appropriate.

Treatment and Care

Rehabilitation is predominantly provided within a Cognitive Behavioural/Neuro-behavioural Therapy approach.

Days/ hours of operation

This service is predominantly a 9am – 5pm, Monday – Friday, with flexible evening clinics being arranged as necessary.

3.3 Population covered

Core referrals are received from the MDT's at Samuel Johnson Hospital in Lichfield and Sir Robert Peel Hospitals in Tamworth. Additional services are provided to other areas upon request.

3.4 Any acceptance and exclusion criteria and thresholds

We do not currently provide a service to individual's over 65 years of age with possible or diagnosed dementia nor acute psychosis. Referrals for individuals with potential dementing illnesses should be directed towards the regional Dementia Service, whilst those with acute psychosis should be directed to Adult Mental Health.

In addition, individuals with pre-diagnosed learning difficulties may be directed towards the Learning Disabilities teams (subject to individual requirements). We are unable to provide specialist pain service or Health Psychology service. We are also not in a position to accept

referrals for non-organic presentations of neurological concerns (non-epileptic attack disorder (NEAD), conversion disorders, factitious disorders etc.). Such referrals should be forwarded to the regional neuropsychiatric services based in Birmingham

Referral processes

Referrals are accepted for patients with a registered GP in South Staffordshire with acquired brain injury and/or neurological conditions

See Appendix 1 for a flow diagram detailing the referral pathway to services.

Response times

Response times are determined by clinical need/urgency and fall within National Guidelines for 18 weeks referral to treatment. All urgent referrals will be discussed and prioritised if appropriate.

All referrals are sent an opt-in letter and voluntary questionnaire within a week of referral (except for patients diagnosed with MS). Upon receipt of affirmative 'opt-in' an initial appointment is arranged. Patients diagnosed with MS are offered an initial appointment without completion of the voluntary questionnaire.

Discharge process

In general, discharge will be a process agreed by all parties; the patient, Neuropsychologist, carer and other professionals. People are discharged from the service under the following circumstances:

- On successful completion of treatment
- After a DNA and failure to then respond to follow-up communication
- If they are assessed and needing referral on to another service
- If they decide they want to cease sessions

Wherever possible, discharges are planned and agreed with the service user. Both the service user and referrer are informed of discharge in writing. Discharge report/summaries are written and shared with third parties (as appropriate) and as agreed with the service user.

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

- 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.
- Outcome and satisfaction questionnaires to be completed either by post or a face-to-face interview.
- All professionals involved in the patient's care to be informed of discharge
- Where the patient is involved with other agencies/services, a detailed summary will be sent to them as appropriate.
- A discharge summary will be sent to the referrer and/or GP.

Due to the nature of presenting concerns/complaints it may be appropriate to reassess patients on an approximately annual or bi-annual basis. Under which such circumstances, the patient will not be discharged but will not be seen within the service for between 12 and 24 months.

3.5 Interdependence with other services/providers

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.14 Applicable Quality Requirements (See Schedule 4A-C) 5.15 Applicable CQUIN goals (See Schedule 4D)
6. Location of Provider Premises
The Provider's Premises are located at: The Neuropsychology Department is based at Wilnecote Health Centre, Smithy Lane, Wilnecote, Tamworth B77 5LB (Tel: 01827 838997) with administration based at Tamworth Health Centre, Upper Gungate, Tamworth, B79 7EA (Tel: 01827 308810, ext. 2850).
7. Individual Service User Placement

Service Specification No.	MH_03
Service	Assertive Outreach Service
Commissioner Lead	Nicky Bromage
Provider Lead	Lisa Agell
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

- National Service Framework for Older People DH 2001
- Mental Health Crisis Care Concordat (Feb 2014)
- Refocusing the Care Programme Approach DOH 2008
- No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)
- Mental Health Policy Implementation Guidance <http://www.iris-initiative.org.uk/silo/files/mh-policy-implementation-guide-2003.pdf>

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012
- Up to date statistics can be found on the POPPI and PANSI HSCIC systems

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

Expected Outcomes for Assertive Outreach Service Users:

- Reduce hospital admissions
- Improve engagement
- Reduce length of stay when hospitalisation is required
- Increase stability in the lives of service users and their carers/family
- Improve social functioning
- Reduction of inequalities in health care.
- Service users have access to accommodation suitable for their needs.
- Service users supported to maximise income.
- Service users are supported to retain and gain paid employment
- Service user's carers and families are well informed.
- A whole family approach is taken when working with service users.
- Service users are seen as partners in care and care plans are co-produced.
- To prevent crisis where possible
- To use of outcome measures, including user defined outcomes, to measure success;

3. Scope

3.1 Aims and objectives of service

Overview of the service

Within any population there are a small number of people with severe mental health problems with complex needs who have difficulty engaging with services and often require repeat admission to hospital. The Assertive Outreach service is provided for within CMHTs and aims to provide assessment, treatment and support for individuals who have severe and enduring mental health needs (requiring care co-ordination) and who have difficulty engaging with and complying with services. The focus of the service is that of recovery and social inclusion and to ensure that the individual's need for treatment and support in the community is appropriately met and that they are assisted in moving towards personal recovery goals.

The Assertive Outreach service will be delivered to the following aims and objectives:

- Care assessment and planning views a person in 'the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical well-being.
- Utilise a team approach in the delivery of a service, rather than working as individual practitioners
- The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, and goals and aspirations as well as their needs and difficulties. It recognises the individual first and patient/service user second.
- Actively involving each service user and their family/carer in planning a programme of support and treatment, ensuring that they are provided with appropriate information and guidance.
- The Service will be provided within the principles defined by Refocusing the Care Programme Approach; *Policy and Positive practice Guidance*; DOH (March 2008)

3.2 Service description/care pathway

Assertive Outreach Service description/ care package- overview i.e. what is provided

Assessment and planning

Assessments will enable the team to monitor progress and change on a number of different levels, including mental state and social functioning. The principles of self-assessment are integral to all assessment processes. Once the assessment has been completed the multi-disciplinary team will meet to discuss the results of the assessment, the outcome of which will be communicated to the referrer.

The holistic assessment process carried out by the Assertive Outreach Service will include:-

- Current problems and difficulties, Sleep, Appetite, Mood, Risk management, Smoke/drink/illicit substances, Forensic, Family history, Personal history, Abuse, Children/pregnancies, Occupation of time, Medical history, Medication, Current accommodation, Financial status, Expectations of treatment Alternatives to Assertive Outreach, Overall mental state
- Social, physical and spiritual assessment

- Care co-ordination documentation will be completed as a summary of this detailed assessment and a care plan agreed upon between the service user and the team. This reflects the needs identified from the assessment and these will be considered and the care plan amended, if necessary, following each review. Reviews will take place at a minimum of six months, or more frequently, if service users needs dictate.

Interventions

All Assessments, interventions, treatments and reviews will follow the CPA framework and are recovery focused they include:-

- High priority given to providing services and support to service users and family/carers in the
- initial stages of engagement
- Persistent repeated approach to engagement
- Capacity to visit 7 days a week
- Capacity to respond rapidly to changes in need and provide intensive support in the community
- Ongoing assessment of need including home assessment, risk assessment and risk management, Relapse Prevention plans
- Work with carers and families
- Ongoing engagement to establish a therapeutic alliance
- Clinical and professional interventions over a sustained period.
- The team will support service users in accessing physical health and dental care and primary care needs
- The team will support service users in accessing other services in the community to meet their needs
- Plans will be reviewed at weekly multi-disciplinary reviews.
- Plans will be reviewed at least 6 monthly through the Care Co-ordination system.
- All therapeutic interventions will be evidence based.

Support with medication

Taking a proactive approach to treatment, this will be aimed at assisting service users to obtain stability of their mental state through monitoring and administration of medication as well as encouraging concordance.

The team will liaise with the person's own GP re medication and physical health issues.

Non-medical prescribing will be robust within each team and will be actively used in relapse prevention, and the monitoring/detection of side effects.

Psychological Support

A range of evidence based psychological interventions will be available to service users to assist them in developing coping strategies and in dealing with symptoms that they may experience over a sustained period.

Social / Practical Support

Practical support in assisting service users in dealing with benefit claims, acquiring appropriate accommodation and coping with daily living tasks is essential in helping people to improve both their place in the community and quality of life.

Support to Family and Carers

Where the service user is agreeable families will be actively involved in the process of assessment and care planning. This will include the provision of information and advice as well as opportunities for programmes of education and support and where relevant, family therapy.

Social / Occupational Activity / Employment Opportunities

Occupational, educational activities will be a main focus of the team and will be aimed at enabling service users to acquire skills, concepts, roles, Knowledge and attitudes encouraging the development of a socially valued lifestyle - increasing self-esteem and developing independence.

Occupational, educational activities will be linked to strengths and wishes; identified by service users using specific assessments such as the interest checklist and Canadian Occupational Performance Measure (COPM).

The importance of service users gaining regular occupational activity, as well as employment, will be seen as a vital component in helping service users attain valued roles within their community and achieve stability.

A positive approach to encouraging service users in developing social/occupational and employment opportunities will be ensured. There will be a focus on the positive attributes of service users in helping them to access a wide range of community facilities.

The approach to the delivery of such services will place equal priority upon each of these areas of need. This is with the understanding that the neglect of social forms of support in favour of other treatment/therapeutic interventions, or vice versa, will limit the effectiveness of any one intervention and undermine the core aims of Assertive Outreach.

Communication

- The provider will ensure that it provides all the information specified by the commissioner and that it communicates effectively and regularly with stakeholders.
- Service users and where appropriate their carer/family members will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.
- All members of care teams supporting service users will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.

Care Pathways – See Documents to be Relied on Schedule 5A

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford and surrounds, Cannock Chase, East Staffordshire, South East Staffordshire, and Seisdon

3.4 Any acceptance and exclusion criteria and thresholds

CRITERIA FOR ASSERTIVE OUTREACH

Adults aged from 18 years presenting with one or more of the following:-

- A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a risk of reduced functioning
- A history of high use of inpatient or intensive home based care (for example, more than two admissions or more than six months inpatient care in the past two years)
- Difficulty in maintaining lasting and consenting contact with services
- Multiple, complex needs including a number of the following:

- History of violence or persistent offending
- Significant risk of persistent self-harm or neglect
- Poor response to previous treatment
- Dual diagnosis of substance misuse and serious mental illness
- Detention under the Mental Health Act (1983) on at least one occasion in the last 2 years
- Unstable accommodation and homelessness

Exclusion criteria for Assertive outreach

- The Assertive Outreach Service will not ordinarily accept referrals for individuals with a primary diagnosis indicating an organic brain syndrome/disorder or borderline personality disorder.
- Children under the age of 18 years

Days/ hours of operation

Assertive Outreach = Monday – Friday 08:00 – 20:00
Saturday-Sunday 08:00-16:00

The service can and does operate outside these hours in response to Service User need.

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, CMHT's, CR&HT, Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. BME communities. Social Inclusion and Recovery Services e.g. Life Links, Changes

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All relevant NICE Guidance complied with

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at: Please refer to CMHT specification for locations

7. Individual Service User Placement

Service Specification No.	MH_06	
Service	Adult Eating Disorders Services – Outpatient/Community	
Commissioner Lead	Nicky Bromage	
Provider Lead	Mel Watson	
Period	1 st April 2022 to 31 st March 2023	
Date of Review	By 31 st March 2023	
1. Population Needs		
1.7 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; JCP http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf - Eating Disorder (NICE CG009)		
Local strategic context - Staffordshire and Stoke on Trent Adult Mental Health Strategy ‘Mental Health is everybody’s business’ 2014-2019 - Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 - Up to date statistics can be found on the POPPI and PANSI HSCIC systems.		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
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 Expected outcomes include:		
- Weight restoration - Establishing regular and balanced eating patterns - A clarification of diagnosis - Stable biochemistry - Identifying and exploring underlying emotional problems - Improved psychological functioning		
Standardised measures should be used to measure outcome (e.g. Eating Disorder Examination Questionnaire, EDE-Q; CORE; HONOS; Clinical Impact Assessment Questionnaire, CIA) as well as considering other factors such as weight, BMI, menstrual		

status, mortality rates and recovery outcomes (e.g. returning to work/college). Patient satisfaction with services should also be evaluated.

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 / under pinning, 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).

Many of our patients will require twenty sessions of CBT-E. A number will require treatment over a much longer duration of time some of whom may require admission to a specialist eating disorder unit for intensive treatment.

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

When working with individuals who have more complex presentations and associated co morbidities, there will be close joint working with the CMHT, ensuring effective liaison and a shared plan of risk management. It will be clear who is Care Co-ordinator for the patient. The roles of each designated professional will be made clear within the care plan.

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.

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.

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.

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
- Medical monitoring
- Support for carers
- Relapse prevention

Diagnostic Criteria

Anorexia Nervosa

Core Features

- Weight loss with weight maintained 15% below expected for height (BMI <17.5)
- Morbid fear of weight gain and of becoming fat
- Amenorrhoea >3 months
- Loss of libido in males
- Distorted body image/self esteem unduly associated with weight and shape

Other Features

- Self induced vomiting
- Laxative abuse
- Excessive exercise
- Low self-esteem
- Depression
- Anxiety
- Social withdrawal

Bulimia Nervosa

Core Features

- Weight generally within normal limits
- Morbid fear of weight gain and of becoming fat
- Objective binge eating (twice a week for the last three months)
- Recurrent compensatory behaviours in order to prevent weight gain (vomiting, laxative abuse, diuretic abuse, excessive exercise)
- Self evaluation unduly influenced by weight and shape
- Dietary restriction

Other Features

- Low self-esteem
- Depression
- Anxiety

EDNOS (Eating Disorder Not Otherwise Specified)

These disorders do not meet the diagnostic criteria for a specific eating disorder, but actually make up the largest percentage of eating disorder sufferers.

Core Features

- Meeting criteria for anorexia but has regular menses
- Meeting criteria for anorexia but weight within normal limits
- Meeting criteria for bulimia but binges occur <twice a week or for a duration less than three months

- A patient with normal body weight engages in compensatory behaviours but does not binge
- A patient who repeatedly chews and spits out but does not swallow the food

Binge Eating Disorder

Core Features

- Weight generally above normal limits
- Recurrent episodes of binge eating characterised by both:
 1. Eating in a discrete period of time an amount of food that is definitely larger than most people would eat in a similar period of time
 2. A sense of lack of control over eating during the episode
- Marked distress regarding binge eating
- Binge eating occurring, on average, at least twice a week for a 6 month period
- The patient does not meet the criteria for bulimia and does not utilise compensatory behaviours in an attempt to avoid weight gain

Other Features

- Low self esteem / shame and guilt
- Depression
- Anxiety

Response Times

Response times are determined by clinical need/urgency and fall within National Guidelines for 18 weeks referral to treatment. All urgent referrals will be discussed and prioritised.

Discharge Process

In general, discharge will be a process agreed by all parties; the patient, therapist, carer and other professionals. In cases where the patient is unable to utilise treatment then the GP will be asked to take responsibility for monitoring and risk assessment. 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. All professionals involved in the patient's care will be informed of the discharge and the care plan.
3. Where the patient is involved with other agencies/services, a detailed summary of the treatment and relapse plan will be sent to them.
4. 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

South Staffordshire CCG populations within the localities of Stafford, Cannock Chase, East Staffs, South East Staffs and Seisdon.

3.4 Any acceptance and exclusion criteria and thresholds

The service provides an out-patient/community service for adult patients, both male and female who are aged 18 and over, who suffer with an eating disorder. 16-18 year old will be accepted following inpatient admission if deemed clinically appropriate to their needs. Only referrals for 17 ½ year olds who are likely to require treatment beyond 18 can be accepted.

Exclusion Criteria

- 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 with flexible evening and Saturday clinics being arranged as necessary.

Referral Process

Referrals are 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. A letter will then be sent to the individual asking them to contact our service to arrange an appointment that is convenient to them. A comprehensive assessment is then conducted by one of our senior clinicians, the outcome of which is discussed within the multi disciplinary team and treatment options discussed and agreed.

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

Referral Criteria

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

3.5 Interdependence with other services/providers

NHSE commissioned Eating Disorders Inpatient provision.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

All relevant NICE Guidance complied with

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).

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.3 Applicable Quality Requirements (See Schedule 4A-C)

5.4 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

The Eating Disorders Service is based at St Chads, St George's Hospital, Corporation Street, Stafford, ST16 3AG (Tel: 01785783120)

7. Individual Service User Placement

Service Specification No.	MH_07	
Service	Acute In Patient Service - Functional	
Commissioner Lead	Nicky Bromage	
Provider Lead	Lisa Agell	
Period	1 st April 2022 to 31 st March 2023	
Date of Review	By 31 st March 2023	
1. Population Needs		
1.8 National/local context and evidence base		
Policy context		
- Department of Health, 2002 “National Service Framework Policy Implementation Guidance”. - Department of Health 2008, Mental Health Act 1983 Code of Practice - Department of Health, 2005 “The Mental Capacity Act”. DoH - No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011) - Closing the Gap: Priorities for Essential Change in Mental Health (Feb 2014) - Mental Health Crisis Care Concordat (Feb 2014) - The NHS Belongs to the people: A call to action		
Local strategic context		
- Staffordshire and Stoke on Trent Adult Mental Health Strategy ‘Mental Health is everybody’s business’ 2014-2019 - Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 - Up to date statistics can be found on the POPPI and PANSI HSCIC systems.		
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		
Expected Outcomes for Service Users		
- The support provided to <u>all</u> service users admitted to an in-patient setting will be coordinated via the Care Programme Approach. - Lengths of hospital admissions will be reduced through prompt, comprehensive assessments and multi-disciplinary working relative to identified needs. - Care plans will be designed to manage and reduce positive mental health symptoms - Providers will support a well trained workforce enabled to work with people with complex needs who will work with service users and carers promoting recovery models		

- Care plans will address physical health needs resulting in the reduction of inequalities in health care.
- Care plans will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care.
- Service users will be discharged to accommodation appropriate to their needs, and where required accommodation providers will be active participants of care teams
- Service users will access therapy and social inclusion programmes appropriate to their needs, this will be reflected in care plans and where appropriate providers will be active participants in care teams
- HONOS assessment will be applied at the reviews of service interventions.
- Interventions will include assisting carers and families to gain knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise.
- Service users will be active participants in their care process determining interventions and contact with provider services, where their wishes are over ridden clear rationale for the reasons will be recorded.
- Care Plans will detail the role of carers and they will be active participants in the reviewing process.

Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.

3. Scope

3.1 Aims and objectives of service

Overview of local adult in-patient services

The Inpatient services in Stafford include Chebsey, Bromley & Brocton House are assessment and treatment units. The Inpatient services in Tamworth are provided at the George Bryan Centre which is an assessment and treatment unit. These Inpatient facilities provide care and treatment for both male and female service users (aged 18 and above. Individuals under the age of 18 will be admitted based on clinical need) with broad spectrum mental health needs. Therapeutic activities are delivered on the units that are in line with national guidance.

There are section 136 assessments suites based at each of the sites.

West Wing, George Bryan Centre.

St Georges Hospital Stafford.

The unit's works closely with the Psychiatric Intensive Care Unit (Norbury House) based at St George's Hospital, Stafford.

Norbury is accessed when service users' needs require a level of intense support and observation.

Aims and objectives of service

The service will provide support in an In-Patient setting to service users whose severity of need is such that neither domiciliary acute care (Crisis Resolution/Home Treatment Team) nor acute day care would be sufficient to meet their needs or provide a required level of safety. Admission to hospital will be efficient and well-coordinated and all service users will be fully informed of the reason for their admission and will receive an information pack at admissions which will be in the Service Users first language.

Specialist inpatient care is delivered by a dedicated team of professionals which includes a specialist Consultant Psychiatrist. Inpatient reviews are held daily by the team to avoid delays to the individual patient's pathway and to ensure a swift response to patient requests and needs. A Meeting is held approximately 72 hours after admission to rigorously identify the holistic needs of the individual. Main objectives of the functionalised model include:

- to provide a personalised model of care
- reduction in delayed transfers of care

- provide multidisciplinary specialist care
- diverse therapeutic interventions
- All requests for admission will be made to the Crisis Resolution & Home Treatment (CR/HT) teams, who will assess for the most appropriate care management in the community or possible admission.
- Where the service user is known to the services they will have a Care Co-ordinator or Lead Professional (typically based in a Community Mental Health and Social Care Team) who will provide relevant information to the CR/HT teams prior to any acute assessment taking place. It is required that the Care Co-ordinator must be an active participant in the assessment.
- Service Users who are admitted under the Mental Health Act will have their rights explained to them clearly, sufficiently often and in language such that they can understand their rights.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- The provision of safe and effective mental health inpatient services for those individuals whose mental health needs warrants admission with timely and appropriate interventions.
- Immediate assessment of psychological health and treatment requirements of accepted Service Users commenced within 24 hours
- Risk assessments will reflect any safeguarding issues for vulnerable individuals and where abuse has/or is likely to occur, a referral (VA1) will be made to the appropriate Single Point of Access as per the locally agreed joint policy and procedure on Safeguarding Vulnerable Adults
- Full evidence based multi-disciplinary Treatment package identified within 72 hours which aims to meet psychological, spiritual, physical cultural and gender needs
- Care and treatment which aims to reduce risk to others and self
- Care is offered utilising Recovery philosophies which promote social inclusion, self-confidence, building skills and strengths, offering hope and reducing stigma. The care offered places the individual and their carer at the centre
- Each of the Acute wards offers the Service User the right to independent advocacy
- Provision of purposeful, stimulating and appropriate mental and physical activities
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Establish effective liaison with local Community Mental Health and Social Care, Crisis Resolution and Home Treatment, Assertive Outreach, and Early Intervention in Psychosis approaches to establish processes to manage complex cases.

3.2 Service description/care pathway

Care Pathways – See Documents to be Relied on Schedule 5A

Admission ➡ Assessment ➡ Care Plan ➡ Care & Treatment ➡ Discharge Review ➡
Discharge in accordance with CPA

The service will have the appropriate multi-disciplinary workforce and have the adequate skills mixed to provide the relevant interventions and meet the required service objectives and outcomes.

Discharge process

The discharge process starts on admission and consultation must be documented at first review meeting. This process is in conjunction with the Admissions & Discharge Policy embracing the principles of CPA and Functionalisation model.
All discharge planning occurs with Service User and carer involvement and agreement.

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford, Cannock Chase, , East Staffs, South East Staffordshire and Seisdon

3.4 Any acceptance and exclusion criteria and thresholds Days/ hours of operation The Units are operational 24 hours a day 365 days a year. Referral processes Generally the Acute In patient units receive referrals through the Crisis/Home treatment teams. Emergency admissions I.e. admitted formally under section of the Mental Health Act, or through Section 136 assessments that are deemed suitable for admission. Response times Immediate response. Exclusion criteria • Individuals who do not meet the criteria for alternative to hospital admission • Individuals with dementia • Individuals under the age of 18 will be admitted based on clinical need 3.5 Interdependence with other services/providers The Acute In patient units work closely with the Psychiatric Intensive Care unit (Norbury), the community mental health and social care teams (CMHT), Crisis Resolution & Home Treatment, Assertive Outreach and Early Intervention services, Liaison Psychiatry Teams. There is also collaborative working with the Police, Ambulance service and A+ E departments. There are close working arrangements with the Forensic, Learning Disability, Perinatal and substance misuse services. Key interdependency with Staffordshire & Stoke on Trent Partnership Trust; Acute and General Hospitals, and primary care.
4. Applicable Service Standards 4.1 Applicable national standards (e.g. NICE) All relevant NICE Guidance complied with 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983 Royal College of Psychiatrists April 2013 CR159. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales) Jul 2011 Royal College of Psychiatrists 4.3 Applicable local standards
5. Applicable quality requirements and CQUIN goals
5.5 Applicable Quality Requirements (See Schedule 4A-D)
5.6 Applicable CQUIN goals (See Schedule 4E)
6. Location of Provider Premises The Provider's Premises are located at: St Georges Hospital Corporation Street Stafford ST163AG George Bryan Centre, Tamworth. B78 3NG
7. Individual Service User Placement

Service Specification No.	MH_09	
Service	Psychiatric Intensive Care Unit (PICU)	
Commissioner Lead	Nicky Bromage	
Provider Lead	Lisa Agell,	
Period	1 st April 2022 to 31 st March 2023	
Date of Review	By 31 st March 2023	
1. Population Needs		
1.9 National/local context and evidence base		
Policy context		
• Department of Health, 2002 “National Service Framework Policy Implementation Guidance”. • Department of Health 2008, Mental Health Act 1983 Code of Practice • Department of Health, 2005 “The Mental Capacity Act”. DoH • No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011) • Closing the Gap: Priorities for Essential Change in Mental Health (Feb 2014) • Mental Health Crisis Care Concordat (Feb 2014) • The NHS Belongs to the people: A call to action		
Local strategic context		
• Staffordshire and Stoke on Trent Adult Mental Health Strategy ‘Mental Health is everybody’s business’ 2014-2019 • Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 • Up to date statistics can be found on the POPPI and PANSI HSCIC systems.		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
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		
Expected Outcomes for Service Users		
• The support provided to <u>all</u> service users admitted to an in-patient setting will be co-ordinated via the Care Programme Approach.		

- Lengths of hospital admissions will be reduced through prompt, comprehensive assessments and multi-disciplinary working relative to identified needs.
- Care plans will be designed to manage and reduce positive mental health symptoms
- Providers will support a well trained workforce enabled to work with people with complex needs who will work with service users and carers promoting recovery models.
- Care plans will address physical health needs resulting in the reduction of inequalities in health care.
- Care plans will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care.
- Service users will be discharged to accommodation appropriate to their needs, and where required accommodation providers will be active participants of care teams
- Service users will access therapy and social inclusion programmes appropriate to their needs, this will be reflected in care plans and where appropriate providers will be active participants in care teams
- HONOS assessment will be applied at the reviews of service interventions.
- Interventions will include assisting carers and families to gain knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise.
- Service users will be active participants in their care process determining interventions and contact with provider services, where their wishes are overridden clear rationale for the reasons will be recorded.
- Care Plans will detail the role of carers and they will be active participants in the reviewing process.

Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.

3. Scope

3.1 Aims and objectives of service

Overview of service

Norbury House is an Intensive care environment that provides assessment, treatment and care for those service users detained under MHA who are assessed to require a brief stay and intensive care within a locked environment due to the risks associated with their psychiatric presentation. Informal patients may also be accepted if agreement with the service user is reached and it is deemed clinically appropriate

The unit also aims to provide specialist support to the acute admission wards where requested in meeting the needs of service users whose presentation may include risk to self or others.

Aims and objectives of service

The primary function of PICU is the intensive management of acute mental illness and behavioral disturbance within an integrated care pathway.

The unit is highly staffed and provides short periods of intensive treatment for adults requiring rapid assessment and stabilisation before or during a longer period of inpatient care.

The emphasis is on intensive treatment combined with a range of physical, procedural and relational security measures that will help to reduce risk, disturbance and vulnerability. The care and treatment needs of patients requiring PICU will not be able to be managed safely in the patient's usual ward setting regardless of the level of security provided. In some cases, patients may be admitted straight to PICU.

3.2 Service description/care pathway

Care Pathways – See Documents to be Relied on Schedule 5A

Admission ➡ Assessment ➡ Care Plan ➡ Care & Treatment ➡ Discharge Review ➡
Discharge in accordance with CPA

The service will have the appropriate multi-disciplinary workforce and have the adequate skills mixed to provide the relevant interventions and meet the required service objectives and outcomes.

Staffing capacity should be sufficient to deliver the care and treatment model and maintain a safe environment at all times. Staff mix and ratios should be flexible enough to meet changing levels of risk.

Response times

The response times is within 6 hours of referral all referrals to PICU are subject to MHA

Discharge process

- The discharge process will commence within 72 hours of admission. A 72 hour discharge planning meeting within Care Programme Approach philosophies will occur and will have a focus on the underpinning risk assessment
- Where discharge from the unit occurs, a package of treatment and care and the discharge risk assessment will be agreed with the appropriate multi-disciplinary team responsible for the aftercare and a 48 hour or 7 day discharge follow-up plan put in place.
- All discharge planning will occur with service user and care involvement and agreement

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford, Cannock Chase, , East Staffs, South East Staffordshire and Seisdon

3.4 Any acceptance and exclusion criteria and thresholds

Service Users requiring PICU are likely to:

- Display acute behavioral disturbance that seriously compromises their physical and/or psychological wellbeing of themselves and/or others.
- be at notable risk of aggression, suicide and/or serious self-harm
- be at risk of increased vulnerability because of sexual disinhibition or over-activity in the context of mental disorder.

Following treatment in PICU, patients are likely to continue to receive inpatient treatment in other ward settings.

Days/ hours of operation

The Units are operational 24 hours a day 365 days a year.

Referral processes

Generally the Acute In patient units receive referrals through the Crisis/Home treatment teams. Emergency admissions i.e. admitted formally under section of the Mental Health Act, or through Section 136 assessments that are deemed suitable for admission.

Exclusion criteria

- Individuals who do not meet the criteria for alternative to hospital admission
- Individuals with dementia
- Individuals under the age of 18 will be admitted based on clinical need

3.5 Interdependence with other services/providers

The Acute In patient units work closely with the Psychiatric Intensive Care unit (Norbury), the community mental health and social care teams (CMHT), Crisis Resolution & Home Treatment, Assertive Outreach and Early Intervention services, Liaison Psychiatry Teams. There is also collaborative working with the Police, Ambulance service and A+ E departments. There are close working arrangements with the Forensic, Learning Disability, Perinatal and substance misuse services. Key interdependency with Staffordshire

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All relevant NICE Guidance complied with

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

AIMS – use the information but do not pay subscription.

Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983
Royal College of Psychiatrists April 2013

CR159. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales) Jul 2011 Royal College of Psychiatrists

4.3	Applicable local standards
5.	Applicable quality requirements and CQUIN goals
5.1	Applicable Quality Requirements (See Schedule 4A-D)
5.2	Applicable CQUIN goals (See Schedule 4 part E)
6.	Location of Provider Premises
The Provider's Premises are located at: Georges Hospital Corporation Street Stafford ST163AG	
7.	Individual Service User Placement

Service Specification No.	MH_10
Service	Community Dementia Service East & West
Commissioner Lead	Nicky Bromage
Provider Lead	Lisa Agell
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 National Policy Context It is well recognised that mental health difficulties experienced by older people are common as is the increasing incidence of dementia, and as the aging population continues to rise so will the demand for services. The current national drive to improve outcomes for people with mental health problems is therefore timely in emphasising the need to deliver quality services that will support and maintain the longer term mental health and wellbeing of people. Providing services that are based on need and not age is supportive of equality care, although it is still important to recognise and support the specialist service requirements for older people with mental health problems. (National Dementia Strategy 2009, Everybody's Business, 2005) As with all services, older people's mental health services need to be accessible, tailored to individual need and preferably where possible and safe, delivered within the individuals home environment or local community setting. Providing mental health care in this way is the concern of Community Mental Health Teams, who are considered to be the cornerstone of specialist mental health provision offering assessment, treatment, support and advice to older people and their carers within the home environment or local community setting (Everybody's Business 2005, NICE 2006). National Guidance clearly promotes the value and effectiveness of delivering specialist mental health services whilst the person remains in their home environment and recognises that this approach is more in keeping with the current expectations and preferred choice of older people to receive care that not only meets their needs, but is also provided at their convenience and outside of the more traditional 'bed based' models of mental health care delivery. Best practice in mental health care provision is well evidenced and is supported in the following documents: • DOH, 2001 The National Service Framework for Older People, Department of Health London • DOH 2003, Mental Health Policy Implementation Guide, Community Mental Health Teams, Department of Health, London • DOH 2005, Everybody's Business, Integrated Mental Health Services for Older Adults: A service development guide, Department of Health, London • DOH 2005, Mental Capacity Act, Department of Health, London • DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care • DOH 1983 (amended 2007), Mental Health Act, Department of Health, London	

- DOH 2009, Living Well with Dementia, A National Strategy, Department of Health, London
- DOH 2011, No Health without Mental Health: A cross government mental health outcomes strategy for all ages, Department of Health, London

In addition the NHS Five Year Forward View Plan 2015-16 sends out a clear message regarding the importance of providing services that enhance the quality of life for people with long term conditions, especially dementia, and ensuring that people with mental ill health have an improved and positive experience of community mental health care.

Additional National Guidelines/Policies

- Refocusing the Care Programme Approach DOH 2008
- Dignity In Care DH 2006
- Our NHS Our Future NHS Next Stage Review DH 2007
- Everybody's Business DH 2005
- National Dementia Strategy DH 2009
- National Service Framework – Mental Health DH 1999
- Standards for Better Health Annual Health Check CQC
- Safety, Privacy Dignity in Mental Health Units DH 2000
- NICE Guidance/SCIE guidelines
- Dept of Health Code of Practice MHA 83(07)
- Mental Capacity Act 2005
- National Service Framework for Older People DH 2001
- MHA 1983 (07)
- A New Ambition for Old Age – Next Steps in Implementing the NSF for Older People DH 2006
- Opportunity Age: Meeting the Challenge of age in the 21st Century DH 2005
- Carers policy DH 2009
- Safeguarding Legislation – Safeguarding Vulnerable Groups DH 2006
- The Forward View into action: Planning for 2015/16

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

2.2 Local defined outcomes Service Outcomes

The service will ensure the following outcomes are met wherever possible:

- The support provided to all service users admitted to an in-patient setting will be co-ordinated via the Care Programme Approach.
- Positive clinical outcomes (loss of symptoms, remission or recovery)
- Positive functional outcome (activities of daily living, social interaction, social activity, quality of life)

- Care plans will detail the reasons for the use of psychotropic medication and assist service users in exploring alternative ways to manage positive mental health symptoms
- Care plans will address physical health needs resulting in the reduction of inequalities in health care.
- Service users will engage in assessments and reviews against NHS continuing Healthcare Criteria when their needs indicate this requirement
- HONOS assessment will be applied at the reviews of service interventions.
- Interventions will include assisting carers and families to gain knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise.
- Providers will ensure that the welfare of children deemed at risk is addressed and referrals are made to the appropriate sources to meet the needs of children affected by their carer's mental health issues.
- Service users will be active participants in their care process determining interventions and contact with provider services, where their wishes are over ridden clear rationale for the reasons will be recorded.
- Care Plans will detail the role of carers and they will be active participants in the reviewing process.
- Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.
- Holistic assessment of psychological, spiritual, cultural and physical needs.
- An increase in the number of people with dementia and or older adults complex/enduring mental health problems receiving assessment/care in their own home or a community setting
- Antipsychotic prescribed medication being regularly reviewed to support appropriate prescribing and patient/service user safety
- More older adults supported to remain in their own home for longer
- Support a reduction in the number of avoidable admissions to acute psychiatric inpatient care

Patient/Carer Outcomes

- Patient satisfaction (involvement, decision-making, information, respect and dignity)
- Carer satisfaction
- Patient shows a good level of understanding, during assessment, treatment and care planning
- Patient is getting the treatment and support which are best for their dementia, and their life
- Family members or carers feel well supported
- The patient is treated with dignity and respect

3. Scope

3.1 Aims and objectives of service

The Community Dementia Service will provide a multi-disciplinary service to people with dementia and their carers who are affected by complex and challenging needs. This service will be delivered through teams located in the east and west of South Staffordshire. These teams will have focus on delivering a person centred approach to their service delivery, in line with evidence based research on the management of challenging and complex behaviour in dementia.

- Input into more complex assessment (including robust risk assessment and management plans)

- Behaviour disturbance and complex presentation
- Carer breakdown
- Maximising functioning and safety to enable individuals to live in their own homes where ever possible.

Caring for Carers

- Carers clinics and support groups for people caring for someone with dementia
- Education programmes for carers to teach them how to manage behaviour.
- Support groups for people whose loved ones have gone into permanent care
- Post bereavement support and lifestyle adjustment for carers whose loved ones have died
- Therapy for depressed carers

Intervening in Challenging Behaviour

- Training for informal carers in behavioural management strategies
- Use of Newcastle model to formulate and intervene with challenging behaviour
- Specialist challenging behaviour inpatient units
- Input to day services of other agencies caring for people with challenging behaviour
- Provide support to families at home via community teams

Maintaining Quality of Life, Maximising Function-provided by a combination of SSSFT and the 3rd sector providers such as Alzheimer's Society

- Support to carry on with familiar activities and overcome disability
- Assessment of use of aids
- Neuro-rehabilitation advice
- OT assessment and intervention
- Cognitive exercises – brain gym
- Dementia care mapping
- Walking/swimming/physical activity to enhance function
- Enhancing communication with people with severe dementia – music/touch/poetry/pets
- Advice about driving
- Capacity assessments
- Treating depression in dementia
- Monitoring Prescribing

In addition:

- Improve cross-boundary working, resulting in continuity of care, effective communication and increase of appropriate use of other specialist services, such as discharge from hospital, dieticians and other nurse specialists.
- Increase capacity and manage acute mental problems, without hospital admission. Assist in the development of clinical governance activities such as audit and identification of training needs.
- To provide alternatives to in-patient care.- in liaison with Social Care providers
- To carry out Mental Health Assessments identifying nursing for free nursing care assessments (FNCA) as requested by Primary Care Trust (P.C.T.) and Social Services.
- Completion of SAP 3 or equivalent assessments where a NHS employed nurse is required by law. These assessments may include individuals that do not meet

eligibility criteria for this service therefore number of assessments to be monitored and commissioners informed.

- Ensure that inappropriate or unnecessary treatments are avoided
- Ensure the care is delivered in the least restrictive and disruptive manner possible.
- Equality of access and experience for all actual and potential service users- all those involved in providing the service shall acknowledge and respect service user and carer's gender, sexual orientation, age, race, religion, culture, lifestyle and values. The service will be non-discriminatory and anti-oppressive by way of service delivery and Equality Impact Assessments will be completed as appropriate
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Reduce the stigma associated with mental health care

Overarching service principles

- Work with other care/support services as part of a whole health economy to prevent avoidable admissions to secondary/acute care, whenever possible.
- Work as part of a whole health economy to prevent carer breakdown and facilitate access to other services.

3.2 Service description/care pathway

Service user groups covered (including care clusters, where relevant)

The service provides assessment and treatment for people of all ages presenting complex and/or challenging needs associated with a diagnosis of dementia.

The dementia service provides a multi-disciplinary approach to assessment, and intervention with this client group.

Challenging and complex needs in dementia refers to behaviour of an intensity, frequency and duration that the safety of the person or others is at risk if specialised input is not provided.

Examples of such complexities are:

- Persistent expression of challenging behaviours such as physical and/or verbal aggression
- Re-occurring engagement issues that result in increased risk for the person with dementia and or their carer/s.
- Co-existing severe and enduring mental health issues
- Significant mood disorders
- Psychotic symptoms
- Drug / alcohol misuse
- Self-harm
- Severe self-neglect
- Vulnerable adult issues
- Ongoing safety issues
- Carers requiring intensive input, support or training when other carer support services have been unable to have a positive impact as complexities exist. The indication of complexity is therefore the experience of significance stress or burden on family / carers signifying unmet need and the potential for the placement or continued living at home to break down.

Note: This list is not exhaustive.

Conditions That Are More Appropriately Provided By Other Services:

- Individuals whose assessed needs are classed as low intensity unless specialist intervention is necessary to prevent an imminent risk of deterioration
- Individuals with primary diagnosis (non dual diagnosis) of learning disability, substance misuse, borderline personality disorder
- Individuals with no diagnosis of dementia.
- Individuals with a diagnosis of dementia but not currently presenting with complex or challenging needs.
- Individuals requiring an assessment for diagnosis of dementia

NICE Guidelines 42 (2006) states that behaviour that challenges encompasses a wide range of difficulties that are often experienced by people with dementia and that may also have an effect on those who provide care.

The recommendation from NICE is to provide an assessment and care planning approach, which

includes behavioural management, and this approach should be followed as soon as possible:

“People with dementia who develop behaviour that challenges should be assessed at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour”

The guidelines recommend a range of non-pharmacological and pharmacological interventions for cognitive symptoms and non-cognitive symptoms, behaviour that challenges and for co-morbid emotional disorders that require intensive specialised interventions by a range of professionals.

The assessment should be comprehensive and include:

- Physical health (including pain)
- Individual biography
- Psychosocial factors
- Physical environmental factors
- Behavioural and functional analysis
- Mood disorders
- Sensory Dysfunction

The dementia service teams are multi-disciplinary and will provide a detailed assessment followed by individualised care plan that can be delivered to the intensity the complex situation requires. Admission to hospital will be co-ordinated by the team where the level of need / risk exceeds the level of input community services can provide.

Reference: National Institute for Clinical Excellence, Social Care Institute for Excellence: “Dementia: Supporting people with dementia & their carers in health and social care. November 2006 (amended March 2011)

Services users may receive a range of information, from the following dependent on needs:

- Team Information

- Treatment information
- Complaints procedures.
- Individualised action plan/ reviews/ discharge plans/ risk assessments and single assessment documentation.
- Voluntary sector information.
- Support services information (relevant to need)
- Health promotion information.
- Emergency support information.

Services and evidenced based Interventions

- Assess and review individual needs through CPA/SAP
- Identify requirements and draw up care plans as appropriate
- Involvement in Health Promotion issues
- Identify Safeguarding issues and report any allegation of abuse through joint procedures.
- Refer to other services as appropriate
- Train staff and carers based around the care required for an individual client.
- Regularly evaluate practice through audits
- Monitor medication for effectiveness and side-effects
- Advise on treatment options

Response times:

Within 24 working hours: where the referred person or carer is at imminent risk of injury or breakdown in care

Within 72 working hours: there is no immediate risk of injury or breakdown in care but it is likely that the situation will deteriorate without a swift response

Within 4 weeks: stable risk that is consistent with the team's referral criteria

Care pathways (where applicable to meet each care cluster)

West Midlands Mental health Care Clusters August 2010

19. Cognitive impairment or dementia complicated (moderate need)

20. Cognitive impairment or dementia complicated (high need)

21. Cognitive impairment or dementia complicated (high physical or engagement)

Our main partnerships are with Approach, Alzheimer's Society (Dementia Advisory service), South Staffordshire and Shropshire Healthcare NHS Trust: CHES Services, inpatient units, liaison service, functional CMHT and independent care home providers, Primary care services, Older people's wellbeing service provided by the Local Authority and the care home support service provided by the PCT.

Discharge process

The involvement of the Dementia Service is not time limited due mainly to the nature of the illness i.e. dementia process.

The process undertaken is:

- Full involvement of the individual and their carers as appropriate in all aspects of the discharge process.
- Ensure the discharge process commences as early as is practicable.
- Identify (and include in the patient's notes) the clinical fitness for discharge from service.
- Ensure all individuals receive a comprehensive multi-disciplinary assessment of their actual and potential discharge needs including comprehensive risk assessment.
- Ensure that the needs and wishes of the individual are considered as paramount.
- Ensure discharge plans are clearly documented in the individual's health record
- Relevant transfer protocols (where applicable) will be followed.
- Ensure family and carers are fully informed and in support of the discharge arrangements.
- A detailed discharge letter will be sent to the patient's GP.

Staffing

The team will be skilled and welcoming and will have a good understanding of clients' needs and will have a range of skills and the appropriate accredited training.

The service is provided by a team consisting some of the following:

- Operational Team Leaders
- Consultant Clinical Psychologists
- Clinical Psychologists
- Consultant Psychiatrists
- Mid-Grade psychiatrists
- Nurse Practitioners
- Community mental health nurses
- Occupational Therapists
- Community Support Workers
- Administrative team

Training/ Education/ Research activities

All team members will undertake 'Mandatory' training as instructed by the Trust.

The Dementia service will have a programme of service development matched to its needs-based training analysis. Individual training needs will be developed through the Appraisal process within the KSF framework. A team training plan will be in place for all staff addressing the broader range of skill and capabilities required to deliver an effective service. All staff will have the opportunity to take part in appropriate research and audit activity

3.3 Population covered

All patients registered with GP Practices belonging to Cannock Chase, Stafford and Surrounds, East Staffordshire, South East Staffordshire and Seisdon Peninsular CCGs.

3.4 Any acceptance and exclusion criteria and thresholds

Referral processes

The team accepts all referrals that are initially referred via the single point of access to the Dementia services.

All referrals must have the agreement of the individual's GP.

Decisions regarding appropriate interventions are based on comprehensive and detailed information about the individual and this is provided at referral and is inclusive of any investigations carried out by the GP and any treatment to date.

Referral Criteria

- The referred person is presenting with challenging and complex needs in dementia of an intensity, frequency and duration that the safety and well-being of the person or others is at risk if specialised input is not provided

AND

- Unless they are already an inpatient of SSFT, the referred person must already have a formal diagnosis of dementia established by a recognised health provider according to standardised definitions of dementia

AND

- Following clinicians assessment, it is likely that the referred person is categorised as belonging to care cluster 20 (Cognitive impairment or dementia complicated with high need) or care cluster 21 (cognitive impairment or dementia with high physical and engagement needs) using the West Midlands Care Cluster Definitions

AND

- It is generally expected that the referred person will be presenting with moderate or severe dementia but the decision about their suitability for the service will be based on the severity of the presentation of behavioural symptoms and the level or risk associated with this.

AND

- The person with dementia is presenting: **Behavioural disturbance of such intensity, frequency or duration that the physical safety of the person or others is at risk; or access to, and use of, ordinary community facilities is significantly limited; or there is significant impact on the enjoyment of ordinary family life, or that indicates a high level of distress in the person with dementia; or is causing significant stress or burden on their family/carers indicating the potential for the placement or continued living at home to break down.**

- Examples of behaviours that might be suitable for referral include physical aggression, faecal smearing, inappropriate sexual behaviour, emotional distress, coexisting functional mental health diagnosis, extreme apathy, but the acceptance criteria will depend on an individual assessment of the person's need and level of risk which is key.

Exclusion Criteria

People will not be considered suitable for the service if:

- They do not have a diagnosis of dementia
- The behavioural disturbance is mild and creates no significant risk
- The referred difficulty would be expected to respond to common early intervention strategies (e.g. diagnostic assessment, pre and post diagnostic counselling, cognitive stimulation therapy, general advice about dementia)

- The distress in the carer is not associated with the referred person's dementia
- The need is for social care

3.5 Interdependence with other services/providers

- Care Home Education and Support Service
- Dementia Advisory Service
- Social Care

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE/SCIE Guidance 42 2006 - Supporting People with dementia and their carers

This guidance was reflected in the recommendations of the above strategies. It stated several imperatives in its recommendations, with considerable specificity:

- 'Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities.'....
- 'Carers of people with dementia who experience psychological distress and negative psychological impact should be offered psychological therapy'....
- 'Care managers and care co-ordinators should ensure the co-ordinated delivery of health and social care services for people with dementia.'....
- 'People with mild to moderate dementia of all types should be given the opportunity to participate in a structured group cognitive stimulation programme'

Older people may often suffer from physical conditions and increasing frailty as well as mental ill health. Older people with supportive and extensive social networks tend to be less likely to suffer from mental disorders.

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

4.3 Applicable local standards

It is expected that the service provider will ensure appropriate policy is in place in line with current health and safety and risk management guidance together with appropriate mechanisms for recording, auditing and monitoring feedback on service provision and actions taken to resolve issues.

Safeguarding

When the Dementia Team are involved in assessing people with dementia and or complex/enduring mental health problems they must consider whether there are any safeguarding concerns relating to the patient/service user. Where there is concern for the safety of the patient/service user then it is the responsibility of the professional identifying the concern to notify the appropriate authority.

The Dementia Team should ensure that at the point safeguarding issues emerge they are referred in line with local safeguarding policies and procedures. This is the responsibility of the professional leading the assessment and should be clearly communicated to other partners. For example if the mental health assessment clearly identifies that the adult being

treated is at risk or is a carer for another adult or a parent or lives in a household with children and that these children may be at risk because of the adult/ parental behaviour the responsibility to refer rests with the worker who identified this issue and a copy of the written referral retained in the patient/service user record.

The Dementia Team should follow local procedures making reference to referral processes to ensure that the correct local safeguarding process is adhered to for the protection of adults and children.

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4 part E)

6. Location of Provider Premises

The Provider's Premises are located at:

All referrals must have the agreement of the individual's GP.

The team provides a service across the South Staffs PCT area from the following bases:

West Dementia Services (Stafford& Surrounds, Cannock Chase, South Staffs)

Park House, 12 Park Rd, Cannock, WS11 1JN

Tel: 01543 431529, Fax 01543 431536

East Dementia services (Burton/Utttoxeter, Tamworth, Lichfield and Burntwood)

St Michaels Court, Trent Valley Rd, Lichfield, WS13 6EF

Tel: 01543 441461 Fax: 01543 441424

7. Individual Service User Placement

Service Specification No.	MH_12
Service	Adult Community Learning Disability Teams
Commissioner Lead	Nicky Bromage
Provider Lead	Melanie Watson
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023
1. Population Needs	
1.10 National/local context and evidence base Practice is informed by a number of National and local Policies/ Reports Department of Health (2001) <i>Valuing people: a new strategy for learning disability for the 21st century</i>. Department of Health (2009) Valuing People Now: a new strategy for people with learning disabilities. 'Making it happen for everyone'. Emerson E, Hatton C (2008) <i>People with learning disabilities in England</i> (PDF 571.9KB). Lancaster: Centre for Disability Research (CeDR), Lancaster University Mencap (2010) <i>Getting it right</i>. Department of Health (2012) Transforming care: A national response to Winterbourne View Hospital Department of Health Review. Final report Winterbourne View – Time for Change, December 2014 Transforming Care for People with Learning Disabilities- Next Steps- January 2015 Improving Health and Lives (2011) People with learning disabilities in England 2010 The Francis Report of the Mid Staffs public Enquiry (2013) <u>Health Inequalities</u> Demographic studies indicate that the population of people with Learning disabilities is increasing at a rate of 1% per year with an overall growth of 10% by the year 2020. It is also known that people with learning disabilities have an increased life expectancy attributable to innovation and improvements in neonatal , maternal and general healthcare services, the outcome of these improvements overall increase the complexity of healthcare needs in the future. Approximately 15% of people with learning disabilities display behaviours that are considered to challenge services. There are also a number of health issues that are more prevalent amongst people with learning disabilities; these include respiratory conditions, epilepsy, mental ill health, problems associated with eating, drinking and adequate nutrition, communication difficulties and sensory impairments. Although these health problems should be managed within mainstream health services, some individuals will need the input and support of specialist services working in partnership with mainstream health professionals. These are discussed in more detail below. The health inequalities faced by people with learning disabilities in the UK start early in	

life. The information below is taken from Health Inequalities and people with a Learning Disability in the UK by Emmerson, et al (2011)

People with learning disabilities have a shorter life expectancy and increased risk of early death when compared to the general population. Life expectancy is increasing, in particular for people with Down's syndrome, with some evidence to suggest that for people with mild learning disabilities it may be approaching that of the general population. Nonetheless, all-cause mortality rates. People with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome.

General Health Status

The risk of children being reported by their main carer (usually their mother) to have fair/poor general health is 2.5-4.5 times greater for children with learning disabilities when compared to their non-disabled peers. One in seven adults with learning disabilities rates their general health as not good. These may be underestimates of the poorer health of people with learning disabilities, as carers of people with learning disabilities tend to perceive the person they care for to be healthier than suggested by the results of medical examinations. Health screening of adults with learning disabilities registered with GPs reveals high levels of unmet physical and mental health needs.

Local Strategic Context

A REVIEW OF SPECIALIST LEARNING DISABILITY HEALTH SERVICES IN STOKE AND STAFFORDSHIRE

National Development Team for Inclusion Report (2012)

Staffordshire and Stoke on Trent Service Development Plan for adults with LD, complex needs and challenging behaviour, 2014 - 2016

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

- Ensure clear individualised plans are in place to support effective person centred health care for people with learning disabilities and complex health needs
- Access to a full multi-disciplinary team, as clinically indicated.
- Delivery of care in the most appropriate environment, with effective use of resources.
- Effective use of expertise, promoting multi-disciplinary team working.
- Regular review of service user and carer feedback
- All Service Users needs will be regularly reviewed within agreed timeframes
- Service is local and promotes equity of access
- The use of the Health Equalities Framework for all referrals
- Mental health and wellbeing improved

- Joint working with Intensive Support Service (ISS) and Social Care
- Prevention of hospital admissions wherever possible

3. Scope

3.1 Aims and objectives of service

Aim

The overall aim of this service is to provide better outcomes for people with learning disabilities with an assessed need.

The CLDT's will continue to develop in line with both national and local drivers for change, to fit within a whole systems approach for delivering health and social care to people with a learning disability.

They will continue to work in partnership with service users, their carers and other relevant agencies, professionals and relevant others. The Teams will provide high quality effective services in order to meet the complex health needs of adults with learning disabilities who are living in the community

The primary strategic goal for Specialist Health Providers is to shift the organisational focus from 'in patient' services and build on the existing community teams to sustain people with specialist health needs in their local community and wider society. This will be delivered in line with the principles of improving an individual's quality of life and will work within the NHS principles and values outlined in the NHS constitution.

Objectives:

- To be the primary point of access for specialist assessment, planning and intervention for people with learning disabilities living in South Staffordshire who have complex health needs that are critical and substantial
- To support the rights of people with learning disabilities to live good quality lifestyles as valued members of society through promotion of rights, independence, choice and inclusion.
- To provide direct support to people with learning disabilities and highly complex needs including facilitating access to and working in partnership with mainstream health services, if required.
- To provide clinical interventions that support people with learning disabilities to remain within their local community wherever possible and work in partnership as appropriate with the Intensive Support Service (ISS), secondary health services, other providers and the local authorities
- To address health inequalities and meet the health needs of people with learning disabilities through effective, evidence-based health interventions.
- To utilise person centred thinking and person centred tools and promote high quality, safe, efficient, evidence based practice
- To raise awareness of learning disability issues and challenge discrimination and stigma with health staff, employers, education, social and community groups and other agencies as necessary
- To provide supportive, flexible, and innovative individualised solutions for people and their families and carers
- To work in close partnership with other organisations and where required support prompt and timely discharges

The teams aim to ensure that all service users have;

- A timely and appropriate person centred service.
- A smooth transition between services.
- Are included in decision making.
- Have accessible services.
- Have accessible information.
- Have a care plan that they have contributed to.
- Have the opportunity to give feedback on the service.

3.2 Service description/care pathway

The CLDT will:

- Provide person centred, holistic and specialist assessment of people with a learning disability with health needs that cannot be met effectively by generic health care services.
- Deliver effective time limited interventions and reviews for individuals with learning disabilities who have critical or substantial needs, working closely with GP's and Primary Care.
- Support generic health care providers to make reasonable adjustments to ensure good health outcomes for people who have learning disabilities
- Ensure that individuals have a comprehensive person centred care plans and health action plans and where appropriate behaviour support plans to enable and promote good health outcomes
- Provide accessible care plans; service information and satisfaction questionnaires facilitating person centred care and service development.
- Provide on-going review for service users who are typically known to have a higher risk of relapse or who may not require regular input, but would benefit from less frequent face to face review to ensure that appropriate and safe support mechanisms remain in place.
- In the event of a service user requiring a hospital admission, the Community Team will work closely with the Commissioners to identify effective person centred solutions to meeting health needs
- Develop and promote independence, reduce the dependence on specialist services.
- Work in partnership to provide evidenced based, person centred care, deliver improved outcomes, reduce health inequalities and support individuals to continue to live in their chosen setting and local community.
- Work closely with social care, Children and young people (LD) and CAMHS services, education providers, health providers, local authority, service users and their families to carefully plan and understand the needs of young people moving into adult services
- Support the Commissioners in reviewing the needs of people who are currently living in health accommodation locally within privately provided health placements. Provide advice and support to the SSSFT Out of area team in relation to people placed out of county as part of their agreed contract.
- Appropriately signpost referrals to other services/support people to access other services, when necessary
- As appropriate provide health promotion and education for individuals with complex healthcare needs and their carers.
- Work with the Complex Case Nurse (Staffordshire and Stoke on Trent CSS) in respect of supporting the discharge planning process and ongoing care plans for people with complex needs and challenging behaviour in the out of area placements (e.g. Winterbourne cohort) and who need to be repatriated into Staffordshire
- Work in partnership with the Intensive Support Service (ISS) to ensure positive and safe approaches to people who may be at serious risk of breakdown in health and living circumstances
- Work closely with mental health professionals and Clinical Nurse Specialists in primary care to support access to services

Referral Procedure

Anyone can make a referral (including a self-referral), with the consent of the person being referred where possible.

The team can be contacted for information and discussion, prior to a referral being made.

The services accept referrals for adults with a diagnosed learning disability who are ordinarily resident in the locality covered by South Staffs and Shropshire NHS Foundation Trust and are permanently registered with a GP in the South Staffordshire Clinical Commissioning Group area and meet the requirements of the DH Responsible Commissioner Guidance.

Intake Team Process

(See CLDT Referral Acceptance Pathway Appendix 2)

- Referrals will be screened by the Duty Clinician on receipt of referral and risk assessed.
- Duty clinician will decide if the referral is eligible for assessment and screening by the Intake Team
- All eligible referrals will be taken to the Intake Team meeting within one week for allocation for assessment and screening.

All referrals are given an initial assessment to identify needs and suitability of access to the service. This will be by home visit, clinic appointment or appointment within other premises

3.3 Population covered Response times

All referrals will be seen by the Intake team within two weeks

A request for involvement in an Emergency/Urgent situation is considered on the basis of priority and need. Whilst we endeavor to be sensitive and flexible to each service user's individual needs, a decision regarding the availability of their most appropriate resource and the primary need of the person with learning disabilities is the prime consideration. If the referral is appropriate the person will be seen within 24/48 hours.

The teams do not provide out of hours crisis response.

Care pathways

The teams operate within NICE guidance and local agreed pathways. The teams currently ensure care is evidenced based and in line with these pathways. The Epilepsy pathway is utilised when receiving a referral for complex epilepsy. Physical Health and Nutrition and hydration care Pathways are also utilized as appropriate. The Teams are currently using the Health Equalities Framework .The Health Equalities Framework (HEF), an outcomes framework based on the determinants of health inequalities and provides a way for all specialist learning disability services to agree and measure outcomes with people with learning disabilities.

Discharge process

The discharge of service users requires a structured approach to ensure that trust and confidence is maintained. Responsibility for the effective discharge of service users lies with the professional involved in providing the service. Discharge normally takes place once an intervention has been successfully completed and needs have been effectively met.

In some circumstances, discharge may take place as a result of non- compliance with the service/ and or intervention. These decisions are made following non attendance at 2 appointments, despite every effort to ensure engagement; and/or with the agreement of the team following non engagement with the service.

Team structure

The team comprises of:-

Community Learning Disability Nurses (including nurse prescribers)

Nurse Clinical Specialists

Occupational

Therapists Consultant

Psychiatrists

Clinical Psychology and Counselling Psychology

The teams are supported by Speech and Language Therapists from primary care. The teams work with people with a diagnosed learning disability over the age of 18 years. In order to be an appropriate referral the person needs to have a learning disability and complex needs and require specialized support from the team. (See Eligibility Criteria Appendix 1)

Skill mix

The Community Learning Disabilities Teams provide a range of professional services in order to meet individuals specialist needs, which includes:

- Learning Disability Nursing
- Psychology
- Consultant Psychiatry
- Occupational Therapy
- Speech and language Therapy via external referral SSOTP
- Physiotherapy via external referral
- Dietician via external referral

- Advanced Nurse Practitioner in Epilepsy Nursing
- The teams are supported by administration and clerical staff which includes medical secretaries.

All professionals are validated by their professional body:

- Speech & Language Therapist – The Royal College of Speech and Language Therapists (RCSLT)
- All Allied Health Professionals – Health and Care Professions Council (HCPC)
- Occupational Therapists – British Association of Occupational Therapists and College of Occupational Therapists. (BAOT/COT)
- Nurses – Nursing & Midwifery Council (NMC) and Royal College of Nursing (RCN)
- Psychiatrists - Royal College of Psychiatrists (RCPSYCH)
- Psychologists - The British Psychological Society (BPS)

Training/ Education/ Research activities

All team members are required to complete both statutory and professional training. Each staff member will have a Personal Development Plan that identifies additional training needs and interests.

The team will comply with the Trust's mandatory training programme and all staff will have an annual appraisal at which training needs are identified.

All staff will have the opportunity to take part in appropriate research and audit activity.

Consultant Psychiatry

Learning disability psychiatrists are the only professional group trained specifically to assess and diagnose the full range of mental and developmental disorders that can occur in people with learning disability. In addition they have expertise in the diagnosis and management of the full range of epilepsy disorders that can occur in adults with a learning disability. Patient presentations are often complex and assessments often produce multi-axial diagnoses. Learning disability psychiatrist's basic training in general medicine allows them to identify when a physical illness might be a factor in the presentation. Learning disability psychiatrists have the necessary expertise to assess, diagnose and treat in the following areas.

- Mental health problems
- Autism spectrum disorders
- ADHD
- Epilepsy
- Tic disorders
- Syndrome disorders

Close liaison with colleagues in other services is essential throughout this process. Psychiatrists are part of the community learning disability multidisciplinary team, but also work closely with the following:

- Local Authority social work teams
- General practitioners and primary care workers
- Mental health services including CMHT's and CR/HT
- Doctors in other specialities
- The police
- Deprivation of Liberty teams.

In conjunction with their main role, learning disability psychiatrists have expertise regarding the Mental Capacity Act and the Mental Health Act and their application in respect of adults with learning disability. The Mental Health Act Code of Practice specifies that learning disability psychiatrists must be involved in the assessment of patients with learning disability.

Community Learning Disability Nurses

The key areas in which the community learning disability nurses provide services are:

Behaviour that challenges or impacts on the persons quality of life

Autistic Spectrum Disorder, where the person has a learning disability. This may include advice around behaviour, sleep, anxiety and routines

Mental Health/mental illness including monitoring of medication where the person cannot access generic mental health services

Nurse Prescribing

Sleep disorders related to behaviour or mental health

Sexuality and relationships where there are complex issues and risks

Epilepsy

Dementia and age related disorders

Assisting individuals to access specialist health services by providing information and education

Contribution to specialist assessments including CHC assessments

The Promotion of Physical and mental health in order to improve functioning to aid other aspects of referral to include "reasonable adjustments" where needed

Health related bereavement and loss support.

Occupational Therapy

Occupational Therapists aim to offer adults with learning disabilities

- Specialist assessments and advice of daily living skills to identify the level of support or accommodation required.
- Specialist assessment and advice on sensory processing and its impact on behaviour and function. This is often completed in collaboration with other disciplines.
- Specialist environmental assessment to address difficulties in coping with everyday activities.
- Contribution towards specialist dementia assessments for clients with learning disabilities.
-

Psychology

The Psychology Service offers adults with learning disabilities in South Staffordshire who have identified psychological needs which can be addressed by one of the psychological therapies or approaches. We offer clinical and counselling psychology to focus on factors that influence how people feel, think and behave.

This is achieved in a number ways including:

Providing assessment and formulation of clients' needs.

Providing psychological therapies to help clients' and their significant others using a range of approaches including behavioural, cognitive, systemic, and psychodynamic therapies.

Contributing to the development of high quality services and the evaluation of their effectiveness.

The team uses a range of theoretical approaches to inform their work including cognitive, behavioural, psychodynamic, narrative, systemic and community psychology approaches.

Team members have specialist areas of interest and knowledge and we draw on these skills to ensure a high quality service delivered by the whole team.

All the multi-disciplinary professions regularly provide placements for doctoral trainee clinical psychologists, medics, nurses, student nurses and OT's from Wolverhampton, Staffordshire and Keele Universities.

The Districts of South Staffordshire covered by Community Adult West Team

Cannock and Stafford CCG Areas

Districts covered by the Community Learning disability East Team:

East Staffordshire and South East Staffordshire and Seisdon Peninsula CCG.

South Staffordshire Population 106,300

South Staffordshire is a largely rural district made up of several villages with Codsall acting as the administrative centre. The district shares a considerable border with the West Midlands conurbation and is heavily influenced by these areas, particularly Wolverhampton and Dudley.

The working-age population of the district is estimated to be 63,400, of which 17% have a declared disability. Around 5% of the working-age population are from a Black or Minority Ethnic background. The overall population is expected to fall slightly over the next 20 years by around 3.3%, however in the 65-79 age group this is set to increase by around 34%.

Cannock Chase Population 94,400

Cannock Chase is a district of contrasts containing the two large urban areas of Cannock and Rugeley, separated by the Cannock Chase area which is designated as an area of outstanding natural beauty.

The working-age population is estimated to be 59,200; around 24% of those have declared that they have a disability. Around 3% of the working-age population are from BME background. Over the next 20 years the overall population of Cannock Chase is forecast to rise by around 2.3%.

Stafford Population 124,000

Stafford borough consists of two major towns (Stafford and Stone), several villages as well as significant rural areas. The town of Stafford acts as an administrative centre for both the borough and the county.

The working-age population is estimated to be 74,900; some 16.4% of those have declared that they have a disability. Around 4% of the working-age population are from a BME background. The overall population of Stafford district is expected to rise over the next 20 years by around 5.8%.

The Districts covered by the Community Adult East Team

The East Community Learning Disability Team covers the East district of South Staffordshire. This area includes Burton upon Trent, Uttoxeter

Appendix 3

Referral criteria - Intensive Support Service (ISS)

To be eligible for input from the ISS, service users will need to meet the referral criteria for the wider Specialist learning disability health services, and be challenging services/current support networks due to:

- 'behaviours of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy' (Emerson et al 1995)
- significant changes in mental or physical health and wellbeing that are putting the persons placement/home life at risk of breakdown and without intensive intervention and support may result in the loss of their placement/home

And

Require a more in depth specialist assessment and intensive level of support and interventions than can be reasonably provided by the Community Learning Disability Health Team. This may include intensive support to enable successful discharge and transition from an admission into local mental health hospitals or return from independent sector hospital placements.

Uttoxeter (known as east Staffordshire), Lichfield, Burntwood and Tamworth. It is a varied area and comprises of four major towns: Burton, Uttoxeter, Burntwood and Tamworth; one Cathedral City; Lichfield as well as a large rural area with a number of villages of varying sizes.

Burton on Trent is situated in the eastern part of Staffordshire. It is a very varied district with two major towns, Burton-upon-Trent and Uttoxeter as well as a large rural hinterland which is interspersed with a number of villages of varying size. Towards the north of the district the Weaver Hills are an upland area bordering on the Staffordshire Moorlands and the Peak District National Park. The district shares a considerable border with the East Midlands region, and as such has a lot of interaction with parts of the region including Derby, Leicester and Nottingham. Traditionally the district has been heavily influenced by agricultural industry, general manufacturing and the production of food and drink in particular.

Lichfield district is situated in the south eastern part of Staffordshire. It is a mixed district consisting of two large towns, several villages and a significant rural area. The city of Lichfield acts as the administrative centre of the district, the other major town being Burntwood. Major villages include Kings Bromley, Shenstone and Alrewas. The district shares borders with East Staffordshire, Cannock Chase and Tamworth. The area also has significant relations with Walsall and Birmingham. Indeed, these two areas provide important employment opportunities in the district, with a large number of people commuting out of the district into the West Midlands conurbation.

Tamworth is located in the South Eastern corner of Staffordshire. Covering 12 square miles Tamworth is Staffordshire's smallest Districts. In contrast to other parts of Staffordshire, the district shares a boundary with Lichfield to the north and west, and North Warwickshire to the south and east. The town developed around the historic market town which dates back well over 1000 years. Tamworth has experienced considerable growth since the mid-1960s onwards as an expanded town to help accommodate overspill population from Birmingham.

3.4 Any acceptance and exclusion criteria and thresholds

South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Specialist Community Health Teams for Adults with a Learning Disability (SCHALD) work with individuals who have a learning disability and complex health needs requiring specialist support from a range of multidisciplinary health professionals.

Eligibility

To be eligible for this service, people must meet all three of the following criteria:

1. The individual has a learning disability and is over 18 years old.
2. Complex health needs.
3. Difficulties which are critical or substantial in nature that cannot be met via mainstream services.

(See Eligibility Criteria for further detail and exclusions Appendix 1)

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Clinical Nurse Specialists in Primary Care, Service users and carers, GP Practice Teams, Day services, Social Care, Private Providers, Housing, Education, Community Development, Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. Staffordshire and Stoke on Trent Partnership Trust.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2	Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
4.3	Applicable local standards It is expected that the service provider will ensure appropriate Policies and procedures are in place, in line with current health and safety and risk management guidance. Regular audit and monitoring on feedback on service provision and actions taken to resolve issues.
5.	Applicable quality requirements and CQUIN goals
5.3	Applicable Quality Requirements (See Schedule 4A-D)
5.4	Applicable CQUIN goals (See Schedule 4 Part E)
6.	Location of Provider Premises
The Provider's Premises are located at: <u>Location of team</u> The Adult West Community Learning Disabilities Team is based at: The Flanagan Centre St Georges Hospital Corporation Street Stafford ST16 3AG Telephone: 01785-221576 Fax: 01785-221561 Adult Community Learning Disability Team East are based at: 1st Floor of the Friary Centre St Michael's Court, Trent Valley Road Lichfield. WS13 6EF Tel: 01543 442030	
7.	Individual Service User Placement

Adult Community Learning Disability Teams Appendix 1

South Staffordshire and Shropshire Healthcare 
NHS Foundation Trust

A Keele University Teaching Trust

South Staffordshire and Shropshire Healthcare NHS Foundation Trust Specialist Learning Disabilities Directorate

Eligibility Criteria

Specialist Learning Disability Health Service

Eligibility Criteria

South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Specialist Learning Disability Health Service work with individuals who have a learning disability and complex health needs requiring specialist support from a range of multidisciplinary health professionals.

To be eligible for this service, people must meet all three of the following criteria:

1. The individual has a learning disability and is over 18 years old
2. The individual has complex health needs
3. The individual has difficulties which are critical or substantial in nature and that cannot be fully met via mainstream services

These criteria are defined in more detail below.

Definition of a learning disability

The Valuing People Now white paper (DoH 2009) states learning disability includes the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood with a lasting effect on development (This may include associated childhood illnesses for example, encephalitis and meningitis).

Valuing People (2001) emphasises that learning disability encompasses people with a broad range of disabilities. The document recommends therefore, that the presence of a low intelligence quotient (an IQ below 70) is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social support.

Assessments of a Learning Disability

It is recognised that for some individuals, establishing the presence of learning disabilities during childhood, may not have been possible. Consequently, where there is sufficient historical evidence, as well as information about an individual's current difficulties to suggest they may have a learning disability, the Specialist Learning Disability Health Service may undertake a formal cognitive assessment (see appendix 1). This enables the team to:

-
- Clarify an individual's level of cognitive ability and social and adaptive functioning
- Establish whether the specialist learning disability service is the most appropriate team to meet an individual's needs. The risk matrix tool will be used to inform MDT/multiagency decision making in this area.

It is important to note that the presence of a learning disability is not in itself sufficient to ensure input from the Specialist Learning Disability Health Service. To be eligible for the service individuals must also have complex health needs that are critical or substantial in nature. The term complex health need is defined below.

Complex Health Needs

A person is defined as having complex health needs if in addition to their learning disability, they present with at least one of the following:

- Additional impairments i.e. a physical disability, epilepsy, autism, dementia
- Mental health problems where their needs cannot be fully met through mainstream mental health services due to the impact of their learning disabilities. Mental health problems might include; a mood disorder (including anxiety and depression), complex trauma, schizophrenia, complex behavioural needs that challenge, complex physical health needs, long term health conditions and dementia
- Vulnerability related to risk i.e. self-harm, harm to others, neglect and/or disengagement from services
- Complex behavioural needs that challenge
- Require reasonable adjustments to enable access to mainstream services and interventions

An individual's complex health needs must be critical or substantial in nature in order to be eligible for input from Specialist Learning Disability Health Service. The definitions of critical and substantial are outlined below.

Health difficulties which are critical or substantial in nature

Critical need is identified where:

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- Vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial need is identified where:

- There is, or will be, only partial choice and control over the immediate environment; and/or
- Abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- Involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- The majority of social support systems and relationships cannot or will not be sustained; and/or
- The majority of family and other social roles and responsibilities cannot or will not be undertaken.

Exclusion criteria where a learning disability is not present and also have complex health needs that are critical or substantial in nature

The Trust's Specialist Learning Disability Service does not currently provide services for individuals with:

- Specific learning difficulties e.g. dyslexia, dyspraxia where a learning disability is

not also present

- Autistic Spectrum Conditions where a learning disability is not also present
- Individuals with learning difficulties arising from a sensory impairment
- Individuals with an acquired brain injury after 18 years of age
- Children and young people under the age of 18

The Specialist Learning Disability Service is unable to:

- support individuals to attend appointments unless there is a clinical reason to do so
- provide services to individuals who do not have a Telford and Wrekin, Shropshire or Staffordshire GP
- provide externally commissioned legal reports i.e. those to inform Child Care Proceedings, or those relating to forensic/offending behaviour

Conditions which may be confused with learning disability:

- people statemented at school as having difficulty learning with no associated causes or disability e.g. dyspraxia, dyslexia
- people under the influence of long term alcohol or drug/substance abuse
- problems with reading, writing or numeracy only
- emotional difficulties that may sufficiently have disrupted schooling, influencing achievement
- conditions like Attention Deficit Hyperactivity Disorder (A.D.H.D.) or hyperactive disorder
- Asperger's syndrome and some individuals with Autism (a number of people with Autistic Spectrum Conditions do not have a learning disability)
- people with diagnosed mental health issues which impact on cognitive ability or adaptive functioning e.g. dementia
- people with physical or sensory impairments or conditions e.g. cerebral palsy, deafness, epilepsy

Exceptions to exclusion criteria

People who fall within the borderline range of cognitive ability?

On referral to the service the individual will undergo a full screening assessment. Where necessary a range of psychometric and social adaptive assessments will be carried out on which to base a clinical judgement regarding eligibility for services.

Transition from child to adult services

We do not work with individuals under the age of 18. However where a child has complex needs which necessitate a long transition process, the adult team will begin liaising with Child services in order to facilitate a smooth transition to Adult services. Joint working between Child and Adult services may be appropriate.

People with learning disabilities in prison

We are not currently commissioned to work with people when they are in prison. However we would welcome referrals of individuals (who are believed to be eligible) once a release date has been identified so that transition to the community can be facilitated.

Out of county

We are not commissioned to work with people who are placed out of county. However we would welcome a referral as soon as discharge into our area is being considered. We require the opportunity to input into all discharge plans. If we are not involved at this stage we reserve the right to request a delay of discharge if we assess the level of risk as being prohibitive.

Parents with learning disabilities

Where appropriate, individual work is undertaken with parents with a learning disability. The specialist service will undertake assessments and offer advice to inform other services of parents with learning disabilities where there is a need to maintain a child or children living in the family home. However, the specialist service does not provide on-going parenting support to maintain the family.

Requests for IQ tests

All referrals into the specialist service will be screened. At this point a decision will be made to determine whether further assessments are required to a) confirm diagnosis of learning disability and/or b) establish a service users profile of cognitive (and adaptive) strengths and weaknesses.

The service does not take referrals for IQ tests. If following a decision that a person is not eligible for the service or an IQ test is required for some other reason, there will be an option for the referrer to fund further testing. Details of the ways in which scores on IQ assessments are currently classified are included in appendix 1.

Eligibility for additional specialist services

Referral to the Intensive Support and Complex and Multiple Disabilities services we provide is through the single point of access to our Specialist Learning Disability Health Service. Additional criteria will be considered by the Specialist Learning Disability Health Service when deciding which specialist services are clinically indicated. See appendix 2 and 3.

WAIS Scores and what they mean

Classification	IQ Range
Very superior	130 & above
Superior	120 – 129
High Average	110 – 119
Average	90 – 109
Low average	80 – 90
Borderline	70 – 79
Extremely Low	69 & below

Diagnostic criteria - different terms

DSM IV (APA 2004) and ICD - 10 (WHO 1996)	
Mild Mental Retardation	IQ 50/55 – 70
Moderate Mental Retardation	IQ 35/40 – 50/55
Severe Mental Retardation	IQ 20/25 – 35/40
Profound Mental Retardation	IQ 20 or 25
BPS (British Psychological Society)	
Significant Impairment of intellectual Functioning	IQ 55-69
Severe Impairment of intellectual Functioning	IQ < 55

Exclusion criteria

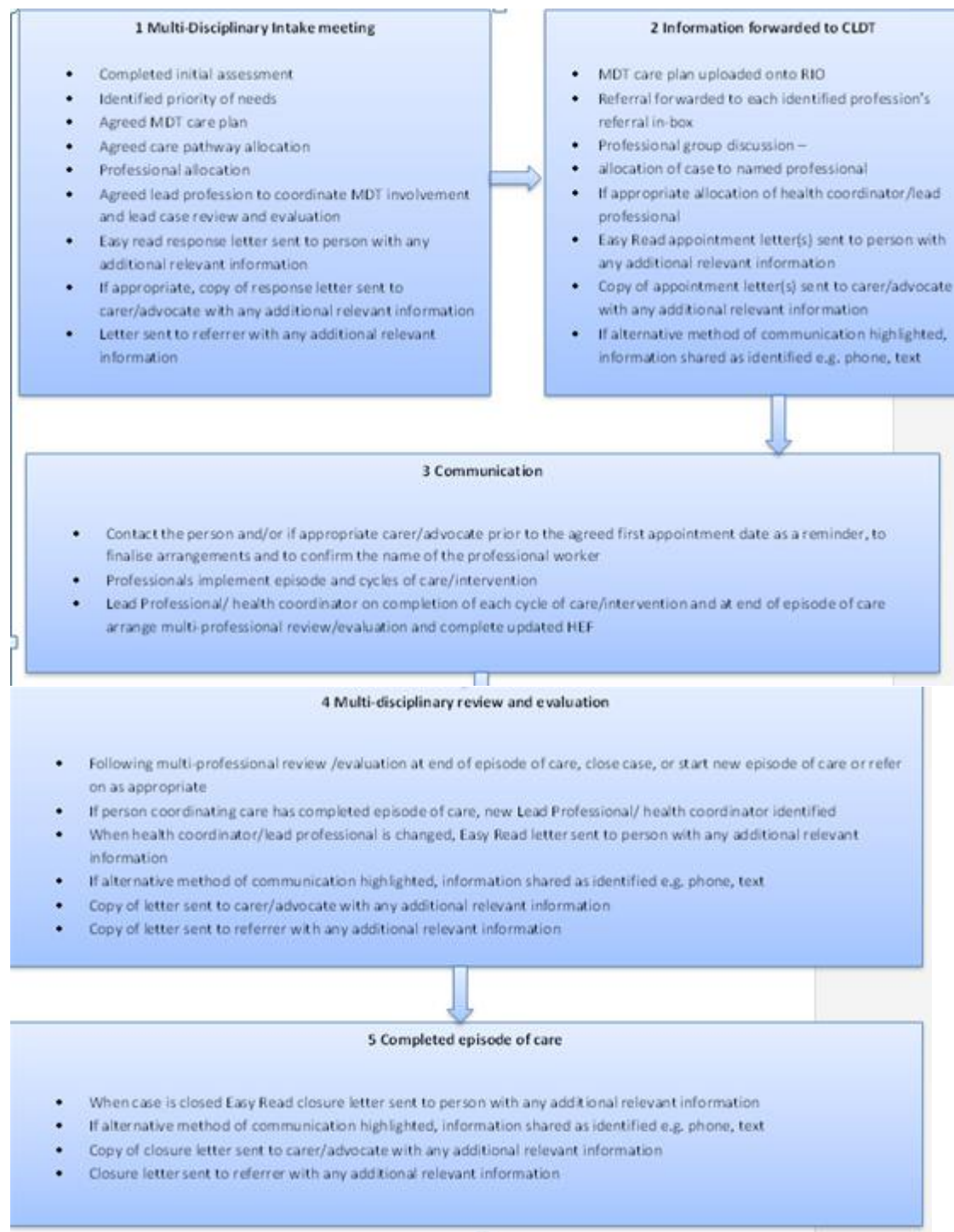
Children (under 18 yrs)

Individuals who may meet the criteria for admission to the service but whose behaviour would increase the vulnerability of the other people who are accessing the service. In

such circumstances, where admission is still required, communication will take place with all parties to agree access and accept the consequential impact

Adult Community Learning Disability Teams Appendix 2

CLDT REFERRAL ACCEPTANCE PATHWAY



Adult Community Learning Disability Teams Appendix 3

Referral criteria - Intensive Support Service (ISS)

To be eligible for input from the ISS, service users will need to meet the referral criteria for the wider Specialist learning disability health services, and be challenging services/current support networks due to:

1. 'behaviours of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy' (Emerson et al 1995)
2. significant changes in mental or physical health and wellbeing that are putting the persons placement/home life at risk of breakdown and without intensive intervention and support may result in the loss of their placement/home

And

Require a more in depth specialist assessment and intensive level of support and interventions than can be reasonably provided by the Community Learning Disability Health Team. This may include intensive support to enable successful discharge and transition from an admission into local mental health hospitals or return from independent sector hospital placements.

Service Specification No.	MH_13
Service	Intensive Support Service (IST) – Learning Disabilities
Commissioner Lead	Nicky Bromage
Provider Lead	Melanie Watson,
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023
1. Population Needs	
1.11 National/local context and evidence base The development of the Intensive Support Service (ISS) has been influenced by a number of national guiding frameworks. Valuing People (DH 2001) states that: • Specialist staff from the learning disability service will if necessary provide support to crisis resolution/home treatment services or other alternatives to in-patient admission wherever possible • In their specialist role staff should recognise the importance of enhancing the competence of local services to enable service users to remain in their usual surroundings and save the high costs (both personal and financial) of specialist placements out of the area. The Mansell Report (2007) “Services for People With Learning Disabilities and Challenging Behaviour or Mental Health Needs” has as its’ first stated aims: Better use of investment is required to achieve two aims: ♦ To develop and expand the capacity of local services for people with learning disabilities, to understand and respond to complex challenging behaviour ♦ To provide specialist services locally which can support good mainstream practice as well as directly serve the small number of people with the most complex challenging needs. Transforming Care: A National Response to Winterbourne View Hospital: Final Report states: Commissioners need to work with providers of specialist services to ensure that community learning disability teams have the additional intensive support they need to keep people out of hospital -including in crises. The report states that local services should include intensive support services in the community. Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services (2015) states: Anyone who requires additional support to prevent or manage a crisis should have access to hands-on intensive 24/7 multi-disciplinary health and social care support at home or in other appropriate community settings. The provision of the IST directly meets a key recommendation of a review undertaken by the National Development Team for Inclusion into specialist healthcare provision for people with a learning disability in Staffordshire and Stoke on Trent (NDTi May 2012). The review’s report	

stated that the local health economy was too reliant on use of bed based NHS services and that resources utilised in this way should be re-invested into community based alternatives.

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

2.2 Local defined outcomes

The service will deliver the following key outcomes:

- Reduced frequency and/or severity of behaviours/complex health needs that challenge services
- Reduce the impact of health inequalities
- Reductions in the numbers of inappropriate hospital admissions.
- Planned out-of-hours support and specification of additional health and social care resources necessary to sustain support arrangements within a community setting
- Development of Positive Behavioural Support plans or Recovery plans for all individuals on the IST's caseload.

3. Scope

3.1 Aims and objectives of service

The main objective of the IST is to provide intensive multi-disciplinary support to people with a learning disability at home or in other appropriate community settings. This service will have the flexibility to provide time-limited and planned support over a 24/7 period.

The purpose of this intensive multi-disciplinary support will be to prevent inappropriate hospital admissions and to enable people with a learning disability and complex behavioural needs to receive safe and effective community based support. This will be achieved by providing a service that works seamlessly with Community Learning Disability Teams (CLDT's) and other agencies.

3.2 Service description/care pathway

The service will:

- Provide multi-disciplinary input from a range of health and social care professionals. This will include joint working with the CLDT. Joint working between the IST and CLDT should be seamless.
- Triage all referrals within a specified time frame and conduct an initial assessment of need. Where a referral does not meet the criteria for involvement appropriate advice and signposting to other services will occur.
- Facilitate risk assessment & management planning processes to manage risks.

- Conduct comprehensive multi-disciplinary assessment and formulation of need. This will occur in conjunction with other services and agencies (e.g. CLDT, local authority, mental health services, support providers; service-users and families).
- Coordinate positive behavioural support planning and focused interventions to support the implementation of agreed strategies. This will include intensive modelling of strategies and staff training.
- Provide planned short-term interventions to help prevent and/or manage crisis scenarios and identify additional health and social care resources necessary to ensure the sustainability of support arrangements within a community setting.
- Work with other agencies to support the transition of people currently placed in hospital back into community based provision.
- Support mainstream services, including mental health services, to recognise and make reasonable adjustments to ensure that people with a learning disability are able to access a full range of health and social care services to meet their needs.
- Ensure appropriate discharge plans are in place when the need for intensive support has ended.

3.3 Population covered

- People meeting the CLDT's acceptance criteria aged 18 and over who are registered with South Staffordshire GP attached to the following CCGs:
 - NHS Stafford and Surrounds.
 - NHS Cannock Chase
 - NHS South Staffs and Seisdon Peninsula
 - NHS East Staffordshire

3.4 Any acceptance and exclusion criteria and thresholds

- The IST will work with people with a learning disability who are eligible and already receiving a service from the CLDT. The IST will work with people if they require a higher level of support than can reasonably be provided by the CLDT under normal operational circumstances.
- Ineligibility for services from the CLDT will exclude a person from accessing services from the IST.

3.5 Interdependence with other services/providers

The IST will work closely with:

- CLDT's
- Local authority
- Transforming Care Team
- Mental Services (community & inpatient)
- GP's and primary care teams
- Clinical Commissioning Groups

4. Applicable Service Standards

4.1 Applicable national standards (.e. NICE)

- NICE guidance NG11 and NICE quality standard 101.

- Professional standards for governing bodies (NMC, RCSLT, COT, HCPC, BPS). - Care & Treatment review, Policy & Guidance, NHS England (2015) - Blue Light protocol (2015) 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) - Challenging behaviour: a unified approach (2007). 4.3 Applicable local standards
5. Applicable quality requirements and CQUIN goals
5.5 Applicable Quality Requirements (See Schedule 4A-D)
5.6 Applicable CQUIN goals (See Schedule 4E)
6. Location of Provider Premises
The Provider's Premises are located at: Michael Flanagan Building St. Georges Hospital Corporation Street Stafford ST16 3AG
7. Individual Service User Placement

Service Specification No.	MH_14
Service	Children's Community Learning Disability Team
Commissioner Lead	
Provider Lead	Paul Andre
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.12 National/local context and evidence base

The community learning disability service will operate in line with prevailing national guidance regarding the provision of assessment & support services. Nationally the current guidance is contained in Transforming Care and the associated guidance 'Building the Right Support' (2015). The following principles are to be supported in the provision of the service:

Principle 1: I have a good and meaningful everyday life.

Principle 2: My care and support is person-centred, planned, proactive and coordinated

Principle 3: I have choice and control over how my health and care needs are met.

Principle 4: My family and paid support and care staff get the help they need to support me to live in the community

Principle 5: I have a choice about where I live and who I live with.

Principle 6: I get good care from mainstream health services

Principle 7: I can access specialist health and social care support in the community.

Principle 8: If I need it, I get support to stay out of trouble.

Principle 9: If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to.

Within South Staffordshire the service will be guided by the work of the Transforming Care Partnership wherein the focus will be on multi-disciplinary working across health, social care & education to sustain children & young people with learning disabilities in the community & avoiding admissions to more restrictive settings (such as Tier 4 accommodation). The service will work closely with the Staffordshire & Stoke on Trent TCP particularly in the utilisation of the Transforming Care Register to identify & risk stratify children & young people at risk of admission. The CETR process will also be utilised to avoid admissions into acute settings.

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	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

The known prevalence rate of a learning disability is 3% of children. Of these 0.3% has a severe learning disability, with a high likelihood of complex health needs. There are 700,000 children with disabilities, under the age of 16, in the UK – this data includes children with physical disabilities who do not have a learning disability. (Family Resources Survey, 2002- 2003).

There are 55,000-75,000 children with a moderate or severe learning disability in England (Learning disabilities: facts and figures, Department of Health accessed online 2007, learning disability foundation). The prevalence of complex health needs in the population of children with learning disabilities is increasing, with an expected increase in levels of severe learning disabilities of about 1% per annum, with an overall increase of 10% by 2020.

It is estimated that the population of children and adults with learning disabilities will rise over the next 10 years, at about 1% per annum, with an overall rise of 10% in the population. The prevalence of learning disabilities is higher in communities of South Asian ethnic background and increases in children & young adults from these communities are expected to rise.

Most children with a learning disability live with their family. The family often provides the significant proportion of care, and their needs for support and care need to be considered in developing and providing any services to children with a learning disability. Whilst some children with highly complex needs may be supported in specialist residential provision (i.e. residential schools with healthcare provision) most children attend local provision of special schools or are integrated into the mainstream school structure.

Details regarding local needs in South Staffordshire are available via the Joint Strategic Needs Assessment

The Children's Community Learning Disability Services aims to provide care for those children and young people within the locality of South Staffordshire in line with local and national policy, the service will incorporate assessment and treatment of children and young people with moderate to severe learning disabilities and mental health difficulties. The service will work closely with other health providers (including providers of services to children & young people with autism as this service is not delivered currently within the community learning disability service), social care providers & education providers & assessors (including the local SEND service)

3. Scope

3.1 Aims and objectives of service

To provide services for children with moderate to severe learning disabilities, who often present a range of associated and complex healthcare needs.

However, the needs of children with less severe learning disabilities should also be considered in the development and delivery of mainstream health services to ensure that barriers to access and inclusion are addressed.

Current transforming care guidance highlights the need to improve service provision at all levels from universal services, promoting mental health and providing early interventions, to highly specialised services. Four tiers of provision guides the commissioning and planning of services:-

- Tier 1: A primary level of care
- Tier 2: A service provided by specialist individual professionals relating to workers in primary care
- Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders.
- Tier 4: Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units.

The Community Learning Disability Team will deliver care at Tier 3 and support and advise other professionals at Tier 2.

3.2 Service description/care pathway

The service model is based on the key principles of Valuing People (2001), Valuing People Now (2007) & Transforming Care (2015) in that all services seek to ensure:

- Independence – the right to live as independently as possible, with the right support.
- Choice – the same level of choice as a citizen and consumer of health services as everybody else.
- Inclusion – the right to be included in community life, to be included in the way that local health services are developed and delivered – this needs to include the right to be included in local Patient Forums.
- Rights – the human and civil rights of any member of society. The right to make decisions about health care and services.

The Children's Community Learning Disabilities Team will aim to work in partnership with service users, their carers and other relevant agencies and health professionals in the team. The Community team will provide high quality effective services in order to meet the complex health needs of children with learning disabilities living in the community.

The teams will ensure that all service users have;

- A timely and appropriate service that meets their need.
- Are included in decision making.
- Have accessible services.
- Have accessible information.
- Have a personal care plan that they have contributed to.
- Have the opportunity to give feedback on the service.

The Children's Community Learning Disability Services will have a common core of skills and knowledge underpinning the specialist expertise, as identified in the *Common Core 2005*.

- Effective communication and engagement with children, young people and families;
- Child and young person's development;
- Safeguarding and welfare of the child;
- Supporting Transitions;
- Multi-agency working;
- Sharing Information.

The Children's' services will work towards achieving the five national Every Child Matters outcomes, and local outcomes as identified in the local Children and Young People's Plan and subsequent plans under the Health and Wellbeing Board Strategy.

- Being Healthy
- Staying Safe
- Enjoying and achieving
- Making a positive contribution
- Achieving economic well-being

The teams will accept referrals on the specific referral forms from any source including service users. However, consent needs to be obtained prior to the referral.

All referrals must demonstrate the need for specialist Tier 3 involvement, see below

The key areas in which the Children's Community Learning Disability team provide services are:

- Behaviour that challenges or impacts on the child's quality of life and warrants the need for specialist tier 3 services.
- Assessment and intervention strategies to manage low mood, fears, phobias, depression and anxiety.

- Psychiatric assessment, diagnosis and intervention for children and young people with moderate to severe learning disabilities.
- Child Mental Health / mental illness including prescribing and monitoring of medication where the person cannot access generic mental health services
- Support to CYP with learning disabilities and mental health conditions who are experiencing crisis, with the aim of avoiding Tier 4 hospital admission.
- Support for other partners e.g. schools, social services and health in managing the psychiatric needs of children and adolescents with learning disabilities
- Support Clinical Commissioning Groups with provision of Care, Education and Treatment reviews for CYP prior to exploring admission to hospital (Tier 4 CAMHS).
- Specific interventions to manage anger for young people.
- The promotion of positive sleep patterns and advice and support on sleep disorders related to behaviour or mental health
- Feeding and dietary needs that are related to the learning disability.
- Self-injurious behaviour
- Support and intervention advice on continence when there is evidence that all interventions by other professionals have been unsuccessful e.g. school nurse, health visitor, continence service.
- Issues related to childhood bereavement and loss that require specialist services
- Education and support around sexuality and relationships in order to ensure appropriate social behaviours are learnt and maintained. These needs will be complex in that they are outside of the education provided in schools around personal and sexual health.
- Complex Epilepsy
- Psychological interventions
- Parenting groups related to referrals for child interventions
- Contribute to assessments in relation to special educational needs (in line with SEND legislation 2013) and children & young people's continuing health care.
- Full adherence to all local safeguarding policies and procedures (children and adults)
- Supporting children & young people in accessing the full range of universal and specialist health provision.

The community learning disabilities team will not accept referrals for the following:

- Supporting carers to attend appointments or to replace them. The team will attend specialist health appointments only if the decisions' being made informs part of the plan of care and this will be time limited within the plan of care. This excludes the provision of transport.
- Continence supplies or assessments that are within the remit of primary care services.
- Out of county support without a contractual agreement
- Monitoring medication and mental health that can be met within primary care
- Social environmental issues
- Employment
- Housing
- Complete welfare / benefit related documentation or assessments towards these.
- Block training on learning disability issues without contractual agreements.
- Referrals where the child has a diagnosis of Autistic Spectrum Condition and the needs are related to autism unless they have a co-morbidity of Learning Disability which requires shared care or where the Learning Disability is the main issue/challenge for the child/young person and family
- Diagnostic assessments for autism-all such work is undertaken via a separate contract
- Provide emergency crisis service and does not provide 24/7 cover.

A request for involvement in an Emergency/Urgent situation is considered on the basis of priority and need. The team will endeavour to be sensitive and flexible to each service user's individual needs, decision regarding the availability of their most appropriate resource and the primary need of the child with learning disabilities is the prime consideration. If the referral is appropriate the child will be seen either the same or next working day. The teams do not provide out of hours crisis response (although consideration should be given to facilitating access to the CAMHS intensive support service where the child/young person has mental health needs)

Screening

- All referrals will receive an initial assessment to identify needs and suitability for access to the service This will be by home visit, clinic appointment or appointment within other premises. This will be within agreed waiting times.
- The screen will be carried out by the most appropriate professional who will feed back this information to the team. From here the team will decide on the appropriate pathway.
- All appropriate referrals will receive a service.
- Referrals that have been known to the service within the last year will require an update prior to specific assessment and intervention.
- Individual needs will be assessed with a variety of tools depending on need and professional responsible.
- If a referral is felt to be inappropriate at any point a letter will be sent to the referrer giving information regarding the most appropriate service to refer on to.
- Service users and their carers will be advised regarding alternative options to meet need and signposting to other services will be undertaken and recorded.

Intervention

Children and young people referred will be offered an appropriate intervention to meet their individual needs. Where possible a choice of the method of intervention will be given. The intervention will be based on the assessment of the professional allocated to work with the child, their family/ and or carers, and will be planned with them. Interventions will be implemented using the best evidence appropriate to meet the child/ young person's need. Intervention will be evaluated with the child/ young person their family/and or carer as appropriate. All interventions are recorded in the child/ young person's Integrated Personal health record, and contacts will also be recorded electronically.

Referral processes

The CLDT works with children and young people who have diagnosed learning disabilities and complex needs and require specialised support from a range of health professionals within Midlands Partnership NHS Foundation Trust.

Criteria for referral.

The Children's Community Learning Disabilities service works with children and young people (under 18years) who have learning disabilities and complex needs and require specialised support from a range of health professionals within the scope of the commissioned service.

In order to receive a service the following two areas of need should be evidenced;

- 1, A learning Disability as defined in 'Valuing people' (2001) and
- 2, Complex healthcare needs, (Valuing People 2001, page 100)

WHAT IS LEARNING DISABILITY?

For the purposes of eligibility, the following definition of Learning Disability based on

the definition within the Department of Health White Paper, "Valuing People" (2001 page 14) will be used.

A Learning Disability is defined to mean the presence of:

- 'A reduced ability to cope independently (impaired social functioning)'

Which:

- 'Is permanent in nature 'and
- 'Started, was identified and was assessed, before adulthood' and
- 'has had a lasting effect on development,' with
- 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), measured as an Intelligence Quotient (IQ) of below 70'.
- The presence of a low intelligence quotient measured as an IQ of 70 or below, is not, of itself, sufficient reason for deciding whether an individual should be provided with specialist learning disability services.

Children and young people with autism who also have learning disabilities and complex needs (including a measured IQ of 70 or below) will be eligible for services if the need is not in relation to their autism alone.

This definition encompasses children with a broad range of disabilities and the services provided will be focused on specific needs.

Response times

The teams will to provide assessment and treatment within 18 weeks for all referrals including GP referrals. In some cases where extensive assessment is required this will constitute a period of treatment.

A request for involvement in an Emergency/Urgent situation is considered on the basis of priority and need. Whilst we endeavour to be sensitive and flexible to each service user's individual needs, a decision regarding the availability of their most appropriate resource and the primary need of the person with learning disabilities is the prime consideration. If the referral is appropriate the person will be seen within either the same or next working day

The teams do not provide out of hours crisis response. The teams will work with generic CAMHS services to provide urgent assessments for mental health needs.

Care pathways (where applicable to meet each care cluster)

The teams will operate within NICE guidance and local agreed pathways. The teams will ensure care is a robust evidence base Care Clusters have yet to be agreed for learning disabilities services.

Discharge process

The discharge of service users requires a structured approach to ensure that trust and confidence is maintained. Responsibility for the effective discharge of service users lies with the professional involved in providing the service. Discharge normally takes place once an intervention has been successfully completed and needs have been effectively met.

In some circumstances, discharge may take place as a result of non-compliance with the service and/or intervention. These decisions are made following nonattendance at 2 appointments, despite every effort to ensure engagement; and/or with the agreement of the team following non engagement with the service. If it is felt that a child or young person may be at risk then other services will be alerted and risk assessment will be completed prior to discharge.

Local safeguarding procedures regarding the reporting of DNAs will be adhered to in full.

Skill mix

The Children and Young People's Learning Disability Team will provide a range of professional services in order to meet individuals specialist needs. This includes:

- Learning Disability Nursing
- Consultant in Child and Adolescent Psychiatrist in Learning Disability
- Clinical Psychology
- Other professionals from the wider team.
- The teams are supported by administrative staff.

The teams are supported by other professionals from the primary care.

Training/ Education/ Research activities

The Children's Community Learning Disabilities service will provide liaison and joint work other agencies e.g. social services, education services, youth offending, voluntary agencies, other health services, autism services and adult mental health and learning disability services.

The service will lead on the development of care pathways for children with moderate to severe learning disabilities and mental health problems.

The service will provide consultation, training and supervision to other professionals working with children and young people with learning disabilities (including associated mental health needs)

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years. Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Safeguarding

The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

As appropriate adult safeguarding procedures should be adhered to in all cases.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance:https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:
https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3.3 Population covered

The service will be available to children & young people (up to age 18) who are the

commissioning responsibility of East Staffordshire CCG, SE Staffordshire & Seisdon Peninsular CCG, Cannock Chase CCG & Stafford & Surrounds CCGs Children & young people who are not the commissioning responsibility of the above CCGs but who are placed by in Staffordshire will not normally access the service apart from via a separate agreement with the CCG responsible for commissioning health services to that individual.

3.4 Any acceptance and exclusion criteria and thresholds

The service accept referrals for children with a diagnosed learning disability who are ordinarily resident in the locality covered by Midlands Partnership Foundation Trust and are permanently registered with a GP associated with one of the above mentioned CCGs in South Staffordshire and meet the requirements of the DH Responsible Commissioner Guidance.

Children & young people who are not the commissioning responsibility of the above CCGs but who are placed by in Staffordshire will not normally access the service apart from via a separate agreement with the CCG responsible for commissioning health services to that individual.

Children and young people will be able to access the service if they have a diagnosed moderate to severe learning disability and are under the age of 18 years. CAMHS LD services will be provided for those children and young people who present with a diagnosable psychiatric disorder.

Shared care/joint working will be provided with partner agencies for children/young people with dual diagnosis, for example:

- Autistic Spectrum Disorder & LD
- Physical Disability & LD
- Substance Misuse & LD
- Mental Health & LD

Please note this list is not exhaustive.

The LD service will provide the Lead Professional where this is appropriate

The service will not see children who have the following without an LD co-morbidity:

- Specific learning difficulties e.g. dyslexia, dyspraxia
- Autistic spectrum conditions
- Learning difficulties arising from a sensory impairment
- Needs and vulnerabilities from social or emotional experiences
- Lack of opportunity
- Drug or alcohol abuse
- Neglect
- Acquired brain injury.

Young people over the age of 18 years.

Transitional arrangements will be developed with adult learning disability services commencing at age 14.

Those who are placed from out of area/county will require a contractual agreement with the placing authority /commissioning body regardless of them having a permanent South Staffordshire GP.

3.5 Interdependence with other services/providers

• GPs & primary care services • Specialist health services including CAMHS & ASD service providers. • Educational services including SEND • Social care services including local safeguarding services for children & adults • NHSE • Universal health services • Parent/carer support organisations. • Service user organisations
4. Applicable Service Standards
4.1 Applicable national standards (e.g. NICE) • Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guidelines, May 2015 • Autism in adults: diagnosis and management, NICE guidelines, June 2012 • NHS England Care and Treatment Review guidance • Positive Behavioural Support Competency Framework • Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services, NHS England, ADASS, LGA, October 2015 • Confidential Enquiry into premature deaths of people with learning disabilities • Guidance for NHS commissioners on Equality and Health Inequalities legal duties 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) • Mansell report: Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (revised), Department of Health, October 2007 • Ensuring quality standards, Local Government Association, NHS England, 2014 • Challenging behaviour: a unified approach - update, Royal College of Psychiatrists, March 2016 • Paving the way: how to develop effective local services for children with learning disabilities whose behaviours challenge, Challenging Behaviour Foundation and the Council for Disabled Children, 2016 4.3 Applicable local standards • Transforming Care Partnership (Staffordshire & Stoke on Trent)-all applicable guidance including the TCP Register & guidance/care pathways re CETR/CTR policy.
5. Applicable quality requirements and CQUIN goals
5.7 Applicable Quality Requirements (See Schedule 4A-C) 5.8 Applicable CQUIN goals (See Schedule 4D)
6. Location of Provider Premises
The provider will offer accessible service locations within all localities of South Staffordshire.
7. Individual Service User Placement
N/a

Service Specification No.	MH_18
Service	Community Paediatrics – Paediatric Audiology
Commissioner Lead	Simon Runnett
Provider Lead	Paul Andre
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023
1. Population Needs	
1.13 National/local context and evidence base General Overview The service is to provide the paediatric audiology component of the local children's hearing services (community and secondary care levels) within the context of a network of children's hearing services • Local children's hearing services will be led by a specialist paediatrician with expertise in developmental paediatrics and training and a special interest in audiology • Paediatric audiology teams will conduct the initial phase of all assessment, diagnosis (including differential medical diagnosis) • To minimise impact on education and development the maximum wait must be 18 weeks to specialist paediatrician led treatment (across whole pathway i.e. 18 weeks from GP referral to initiation of hospital based treatment). For many children it will need to be lower • The service will participate in and facilitate a hearing service network, headed up by a consultant community paediatrician. Commissioners will ensure that any new providers are aware of the hearing service network and provide facilities to meet specified standards • Data collection will develop to ensure demand and capacity in all aspects of the service is fully understood. • Multi-disciplinary approach This Service Specification should be read in conjunction with the Agreement between the Commissioner and the Provider and for the avoidance of doubt forms part of Schedule 2 Part 1. It should be read in conjunction with the service specification for New-born Hearing Screening. This Service Specification is not intended to replicate, duplicate or supersede any relevant legislative provisions which may apply, e.g. of the Health and Social Care Act 2008 or the work undertaken by the Care Quality Commission. The Service Specification will be reviewed by the parties and amended in line with any new guidance as quickly as possible but Commissioners and Providers will work pro-actively to agree variations to the Agreement to take account of any new guidance ahead of the production of a revised Service Specification. Evidence Base • Guidelines for surveillance and audio logical monitoring of infants and children following the newborn hearing screen Version 4.2 NHSP November 2010 • NDCS Policy on Audiology Service Provision in the UK July 2011 • Transforming Services for Children with Hearing Difficulty and Their Families A Good Practice Guide DH August 2008	

- Quality Standards and Good Practice Guidelines: Transition from paediatric to adult audiology services NDCS November 2011
- Quality Standards in Paediatric Audiology Services – Guidelines for the early identification and audio logical management of children with hearing loss NDCS 2000
- Pushing the Boundaries: Evidence to support the delivery of good practice in audiology. NHS Improvement July 2010
- NHSP Standards and Guidelines – National Programme Centre.
www.hearing.screening.nhs.uk
- Guidelines for the early audio logical assessment and management of babies referred from the newborn hearing screening programme NHSP Clinical Group March 2011
- Map of medicine Care Pathway www.mapofmedicine.com
- Modernised Children's Hearing Aid Services protocols and guidelines.
www.psych-sci.manchester.ac.uk/mchas/
- DH Quality enhancement tool for audiology services
<http://audiology.globalratingscale.com>
- Protocols and guidelines issues by professional bodies as appropriate, i.e. BSA, BAAP and BAA.
- NICE Clinical guidelines CG60 Surgical management of children with otitis media with effusion (OME) February 2008
- Safeguarding policies – www.staffsscb.org.uk

Activity

Following service redesign it is possible to estimate annual activity of 2000 per annum but this will be reviewed in year.

Column1	Column2	Column3	Column4
	% under 18 population	% activity paed audiology	% DNA's
Cannock Chase	16	18	15
East Staffordshire	19	19	24
Seisdon Peninsula	16	9	10
South East Staffordshire	30	28	31
Stafford and Surrounds	19	26	20

Population Prevalence

It is difficult to estimate accurately the number of children who will require access to these services. The national prevalence data available is a little contradictory but is available from Chi Mat and from Transforming Services for Children with Hearing Difficulty and their Families: A good practice Guide, DH (2008) – see below.

Chi Mat 2012

In 2010 there were 0.3 per 10,000 population aged 0 – 17 in Staffordshire who were hard of hearing and 2.1 per 10,000 aged 0 – 17 who were deaf.

Table 1: Deaf and hard of hearing children aged 0 – 17 (rate per 10,000 population aged 0 – 17)

	Hard of hearing 0 – 17 (2010)	Deaf 0 – 17 (2010)
Staffordshire	0.3 (4 children)	2.1 (28 children)
England	2.0	2.0

North East	2.1	3.9
North West	2.8	1.8
Yorkshire and the Humber	1.7	2.5
East Midlands	0.9	1.2
West Midlands	3.2	2.2
East of England	1.5	0.9
London	2.8	2.2
South East	1.9	2.3
South West	0.5	1.2

Transforming Services for Children with Hearing Difficulty and their Families: A good practice Guide, DH (2008)

About 1000 babies are born each year in England with Permanent Childhood Hearing Loss (PCHL), of which two thirds will be affected bilaterally. 40% will have severe or profound hearing loss. This means that approximately 1.6 per thousand babies born with have a permanent hearing disorder. An average maternity unit (3 – 4,000 births per annum) will encounter about 5 per year. An GP with an average sized list will look after one deaf child in their entire career and an average GP practice with 5 GP's will probably see on deaf child every 10 years.

A PCT with a population of 500,000 there will be about 10 new cases of PCHL per year with about 40 (0.008%) pre-school and 160 (0.032%) school-aged deaf children in the population. This varies depending on the diversity in the population.

In England an estimated 600 children develop or acquire PCHL by the age of 10 (congenital or genetic causes or acquired loss of hearing following injury or illness).

By the age of 10, in each cohort of children in England there will be 1,200 children with congenital or late onset bilateral hearing loss and between 600 and 800 with unilateral deafness.

At any one time there are about 16,000 – 20,000 children aged 18 or under who have bilateral moderate, severe or profound hearing impairment.

An average PCT (PCTs in South Staffordshire have now been replaced by 4 CCGs) will have around 150 children under the age of 18 with a hearing impairment who should have a joint care plan and 35 children under the age of 5 years affected by PCHL.

30 – 40 % of children with hearing difficulty have additional health needs or developmental problems. 20% will have more than two additional needs. They are more likely to have mental health problems or suffer abuse.

NB. PCHL can present as behavioural and developmental problems or educational underachievement.

There is a disparity in the information provided by Chi Mat and the general data provided by the DH in 2008. The DH information estimates a higher prevalence and should probably be used to estimate activity.

Otitis Media with Effusion (OME) is a fluctuating condition which may result in hearing loss, often transient. 80% of children have had an episode of glue ear by the age of 10 which requires assessment and monitoring by paediatric audiology services.

South Staffordshire PCT

- approximately 6,921 births per year
- Population 609,100

Based on the above information commissioners can estimate the following:

- South Staffordshire CCGs have around 11 children born every year who have PCHI
- 49 pre-school children with PCHL – 15 – 20 children likely to have additional health needs or developmental problems, around 10 of which will have more than one additional health need
- 195 school aged children with PCHL
- 183 children under the age of 18 years with a hearing impairment who require a joint care plan
- Based on this that means up to 26,240 children may require an assessment following OME over 10 year period – 2,624 per year, 50 per week

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

The service will have the following expected outcomes:

- Routine and urgent referrals directly into audiology from elsewhere are seen within time limits which includes all referrals not just those to a consultant
- Hearing assessments take place within a maximum 8 weeks of referral (NDCS recommends assessments within 4 weeks)
- Parents are satisfied with the service demonstrated by routine questionnaires or surveys

In the longer term the real measure of success will be the outcomes for local hearing impaired children in terms of communication, social and educational development and quality of life. This measurement and recording of this is beyond the scope of the specification at this stage.

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service. With reference to the local offer, the service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire

Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years.

Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Safeguarding. The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

As appropriate adult safeguarding procedures should be adhered to in all cases.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national guidance

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:

https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3. Scope

3.1 Aims and objectives of service

Aims

To commission paediatric audiology services which ensure that:

- Children with hearing difficulty are identified, assessed and appropriately managed as early as possible
- Families receive early support from integrated services across agencies
- Changing needs are accommodated
- Services are delivered as locally as possible
- National quality and good practice standards are met
-

Objectives

The key objectives of the service are to:

1. Regard children and their parents as full and equal partners in the team
2. Identify hearing difficulty early
 - a. Through on-going monitoring of high risk cases (egg children with complex disabilities, children with conditions known to be associated with hearing loss, children on ototoxic drugs)

- b. Following serious infection eg bacterial meningitis or septicaemia or injury
 - c. At school entry via diagnostic assessments following the school sweep test (where the policy is implemented)
 - d. Following SALT referral of children with speech and language delay, where hearing loss is suspected
 - e. At any age if there is professional or parental concern
3. Provide rapid, definitive assessment and differential diagnosis in high quality facilities by specialist staff, accompanied by clear accessible information about diagnosis and further management
 4. Refer to the hearing support service provided by the local education authority (specialist service for hearing impaired) for all babies and children diagnosed with permanent childhood hearing impairment (PCHI)
 5. Refer for timely investigations into possible causes of PCHI
 6. Manage and actively monitor children with otitis media with effusion (OME) referring to and working with ENT according to clearly documented and agreed criteria and pathways
 7. Contribute to the multi-agency, multi-disciplinary support and management plan for the child and family
 8. Refer using clear direct pathways to specialist or supra-specialist care as required
 9. Provide on-going care for children with PCHI as part of the multi-disciplinary team as close to home as possible
 10. Systematically monitor the progress of children especially those with PCHI to ensure that support services and any equipment provided are appropriate
 11. Liaise closely with other specialist children's services for the approximately 40% of children with hearing impairment who have additional health needs
 12. Integrate vertically into a wider hearing services network for adults to ensure a seamless transition from children's services to adult services
 13. Participate in the Children's Hearing Services Working Group to contribute to the shaping of services across agencies
 14. Provide accurate and timely information about the effectiveness, quality and any other aspects of the service that is reasonably requested to the commissioners
 15. Ensure that there is a system of clinical governance for all aspects of the service with clear and robust lines of responsibility and accountability
 16. Contribute as necessary to statutory assessment processes for known service users.

3.2 Service description/care pathway

Service Description

The service is to provide the community paediatric audiology component of the local children's hearing services (community and secondary care levels) within the context of a network of children's hearing services.

Community Paediatric audiology services should be organised and delivered so as to facilitate access to services for all children and must provide excellent clinical care and family-friendly support, whilst also ensuring best value and cost-effective use of resources.

The model of delivery will be a tiered approach. This service model enables a clear clinical distinction to be made between the complexity and level of different services that will be provided depending on whether an individual child has a permanent hearing impairment and, if so, the degree, type and configuration of that impairment, and also on their physical, emotional and family needs. It should also ensure that children are seen, tested and managed by professionals with the most appropriate skills and competence working within clear, integrated care pathways.

Within the model shown it is recognised that, in reality, the same staff members could provide services of varying complexity from across the different tiers.

Service Model Audiology Services

Tier/ Level	Services provided	Staff level & experience	Service location
One Not part of this specification but included to show relationship	Note: These services are usually the first point of contact for families • New-born hearing screening testing • Primary management of middle ear infections e.g. otitis and external ear infections • Support for child and family • Alert to mental health and safeguarding issues • Referral for further audio logical and paediatric assessment where appropriate.	General practitioners, newborn hearing screeners & members of the primary health care team. Screeners will have completed training with national programme centre & will have the necessary level of experience. Other professionals are unlikely to have had any specific training in Audiology, but will often have some training in paediatrics (e.g. GPs, Health Visitors).	Hospital, primary/community setting e.g. health centre, General Practice or dedicated children's centre.
Two	Note: These services would be primarily provided to children with permanent hearing impairment without complex needs ¹ • Audio logical	Experienced paediatric audiologists with appropriate accredited training. And/or	These services are located in a hospital audiology department or (where appropriate) within a community

¹ For the purpose of this specification, children with complex needs will be taken to include those children (and their families where appropriate) who require a range of inputs from different professionals/services to meet their physical, social and emotional needs. Excellent communication between, and full co-ordination of, services are essential to help these children reach their full potential.

	assessment of children referred from the newborn hearing screen including those identified for targeted surveillance at 7 – 9 months • Audio logical assessment of children referred from the school entry sweep test • Audio logical assessment of children referred from elsewhere by an appropriate health professional following a high risk event (e.g. meningitis, ototoxic drugs or fracture) or general concern about an individual child's hearing (e.g. in cases of late-onset/progressive hearing loss, speech and language delay, OME) • On-going management and review of children with permanent hearing impairment without complex needs • Referral to and	Paediatricians with clinical experience & training in paediatric audiology and appropriate qualifications	setting.

	co-ordination of services and support with Education, Social Services and other health services. Referral for specialist audio logical and/or paediatric assessment where appropriate.		
Three	Note: These services would be primarily for children with permanent hearing impairment with complex needs ² and/or requiring specialist clinical management of their hearing impairment. - Initial audio logical assessment of babies with atresia/microtia, Down's syndrome - Assessment & on-going management of children with complex needs and/or requiring specialist clinical input for	Third tier services will be provided by a multi-disciplinary team which would be expected to include a Senior Paediatric Audiologist and a Senior Audio-vestibular Paediatrician or Physician, Teachers of the Deaf/Early Support, Specialist Speech & Language Therapists, ENT & other specialist Paediatricians as appropriate. Senior Paediatric Audiologists would be expected to have considerable experience (including working in paediatrics) and an appropriate level of accredited training in paediatric audiology.	These services are located in a hospital audiology department or (where appropriate) within a community setting.

² For the purpose of this specification, children with complex needs will be taken to include those children (and their families where appropriate) who require a range of inputs from different professionals/services to meet their physical, social and emotional needs. Excellent communication between, and full co-ordination of, services are essential to help these children reach their full potential.

	the management of their hearing impairment • Referral for aetiological and paediatric investigation as appropriate • Referral to and co-ordination of services and support with Education, Social Services and other health services. • Referral to other providers of specialist audio logical services e.g. cochlear implant centres	Audio-vestibular Paediatricians/Physicians would be expected to have extensive experience in paediatric audiology and appropriate qualifications/ training (usually an MSc in Audio logical Medicine).	

Referrals

Aim: The aim of the specification is to ensure that patients are able to access services speedily.

1. The Provider will receive referrals from the NHSP as delivered locally.
2. The Provider will also accept direct referrals outside of the screening programme from an appropriate health or other professional
3. The Provider will ensure that there are clearly defined pathways which are widely disseminated and are monitored and reviewed to ensure compliance
4. The Provider will ensure that all children have timely access to the audio logical services which they require.
5. Routine and urgent referrals are seen within the time limits according to locally agreed pathways.
6. The Provider will put in place mechanisms to minimise DNAs and ensure that any patients who DNA their appointment are reported to both the GP and the referrer. Local safeguarding procedures regarding DNA will be adhered to in full.
7. The Provider will post checklists to parents who decline appointments with explanatory letter for targeted follow ups.
8. The Provider will investigate high DNA rates for diagnostic cases and implement measures to reduce these and improve KPI2 measures
9. Waiting times for assessment are monitored effectively and there are sustainable strategies for reducing waiting times if required
10. The Provider will participate in any local or national centralised booking system in agreement with the commissioners e.g. Choose and Book.

Assessment & Diagnosis

Aim: To provide appropriate assessment and diagnosis

1. Patients should be seen with half an hour of their appointment time
2. All children are assessed by audiologists trained to work with children, from a multi-disciplinary team and receive audio logical assessment commensurate with their age

and stage of development

3. The range of audio logical assessments available enables definition of degree and nature of hearing loss
4. Audio logical assessments should follow national guidelines and protocols (as per Section 1.2 Evidence Base.).
5. All assessment tests required should be undertaken in one visit to avoid repeat attendances, minimise inconvenience for the family, maximise workflows and reduce waiting times
6. Testing is carried out in appropriately sound treated paediatric test rooms in line with DH Building Note 12 1994 and built to ISO 8253-1 (1998) and ISO 8253-2 (1998) standards.
7. Accurate and complete audio logical information is gathered to inform decisions about aetiology and prognosis and discussions about further management
8. All audio logical procedures use equipment which is calibrated at least annually and meets national and international standards
9. The outcome of the assessment should inform a clearly defined care management plan
10. Parents are given an appropriate verbal explanation of the audio logical assessment result on the day of the assessment
11. After the assessment parents and referrers are given appropriate written information within 7 days
12. Results of the assessment are reported to the parents, referrer, GP, child health department and any other relevant professionals within 7 days
13. There are written local protocols and care pathways which define management options arising from assessment and comply with national guidance
14. The Provider should ensure that if the child was referred from the NHSP that the screening programme receives (including through electronic systems eSP) written reports of the hearing status of those seen and reviewed in the service. The report should be in a form that accords with the information required by the NHSP.
15. Comprehensive, up-to-date and unbiased written information for parents should be available about aetiological investigations, (i.e. NDCS fact sheet "Why does my child have a hearing loss?") so that parents feel they can make an informed choice.
16. Age appropriate hearing assessment of first degree relatives will be carried out even if there are no concerns about the hearing in other relatives, as previously unsuspected abnormalities may be present. The Provider will develop a local written protocol for carry out parent and sibling audiograms and dealing with any losses detected.
17. Regular reports should be run to identify babies with no follow up data.

Management

Aim: Management of children with hearing difficulties will achieve the best outcomes if they are carried out by appropriately trained and experienced staff, in premises which are suitable, using equipment which is fit for purpose and any procedures or intervention are undertaken in accordance with up to date evidence and best practice.

1. Providers will ensure that informed consent to assessments and/or further management is obtained from the child if Gillick competent and/or the parents or those with parental responsibility.
2. Providers will ensure a high quality of patient experience
3. Providers should ensure that facilities meet the standards laid down in DH Building Note 12 1994 and ISO 8253-1 (1998) and ISO 8253-2 (1998) standards.
4. The Provider should ensure that the screening programme receives (including through electronic systems eSP) the relevant data as set out in NHSP guidance.
5. The Provider is responsible for the on-going management and continuing assessment of children who have been identified as having a hearing difficulty in accordance with national protocols and guidelines. This will include establishing an individual

management plan in consultation with the family.

6. Patient satisfaction with the service is monitored annually, including parent satisfaction on medical aspects of the service.

Family centred care

Aim: Patients should receive a holistic management package.

1. Written information regarding the audiology appointment (directions, maps, car parking, duration, what happens, relevant national leaflets, desired state of the baby, facilities) is provided as part of the appointment process
2. All service staff including reception and administrative staff should receive deaf awareness and communication training on induction and updates every 3 years
3. Patients should be provided with details of support agencies and national and local organisations that can offer support and assistance e.g. NCDS, Deafness Research UK.
4. Services are family friendly with good play areas for patients and siblings
5. Children and young people's views are sought and listened to in respect of management options
6. Audio logical assessments should be carried out by/ under the supervision of senior staff that have the expertise to explain and discuss results with families. It is not acceptable for families to wait for days for information or results.

Exit from paediatric audiology services

Aim: To ensure that children are discharged or transferred from the service appropriately

1. The Provider will ensure clear discharge letters are sent to the referrer and GP and other relevant professionals stating result of assessment, diagnosis, management plan and what to do if further problems in a timely fashion.
2. Transition into adult services or another service are planned for and clearly documented in line with national guidance

Care Pathways

The care pathways for new-borns and older children set out in Transforming Services for Children with Hearing Difficulties (DH 2008) give the framework for the local pathways.

Other pathways from Map of Medicine for early audio logical assessment, amplification, hearing aid fitting and review, PCHI management and cochlear implant further assessment should be followed.

3.3 Population covered

3.4 Any acceptance and exclusion criteria and thresholds

Accessibility/Acceptability

The Provider will accept all referrals received via NHSP and other direct referrals up to the age of 19years if required (recognising that the age of transition to adult services will depend on each case) for children and young people registered with a GP in South Staffordshire PCT area or not registered but resident in South Staffordshire CCG areas.

The Provider must provide equitable access and ensure that services deliver consistent outcomes for patients regardless of:

- Gender
- Race
- Age
- Ethnicity

- Education
- Disability (including access and egress)
- Sexual orientation

The Provider will have procedures in place to ensure equity of access and provide support to those parents who are considered vulnerable including but not exclusive to asylum seekers, parents with substance misuse problems, parents with learning and/or physical disabilities or parents with communication difficulties.

Meets fully the Operating Framework requirements for delivering same sex accommodation if required. DH Guidance

http://www.dh.gov.uk/en/Healthcare/Samesexaccommodation/Practicalsupport/DH_099072

The Provider must adhere to South East Staffordshire and Seisdon Peninsula CCG Patient Access Principles.

The Provider must comply with the Disability Discrimination Act 1995.

The Provider will follow the Principles of patient access policy, South East Staffordshire and Seisdon Peninsula CCG but taking into account patients hearing difficulty and other needs.

The Provider will ensure that information provided to patients is available in suitable formats for children with hearing difficulties and their families and in their preferred language.

The Provider will provide transport for patients who meet patient transport eligibility criteria and in accordance with Trust policy.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373

The Provider will provide information about any reimbursements made to patients, in line with the Hospital Travel Cost Scheme and Trust Policy and recharge the CCGs accordingly.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097374

The Provider will offer appointments at times suitable to children and young people e.g. some should be available outside normal school hours.

Appointments will be offered in specialised facilities suitable for children and young people and will be offered in a single site on the East and a single site on the West (Stafford).

Exclusion Criteria

Patients over 19 years of age.

3.5 Interdependence with other services/providers

Whole System Relationships

The Provider will be required to work in co-operation with:

- The NHSP as delivered in South Staffordshire
- Local General Practitioners
- Local paediatricians (community and acute)
- Specialist Physicians
- ENT
- Health visitors
- School nurses

- Speech and Language therapists
- Teachers of the Deaf
- Local NHS Community Service providers
- Independent and Third Sector Providers e.g. NCDS
- Commissioning CCGs/organisations
- Local Authority Social Services and Education Departments
- Children's Hearing Services Working Group

Interdependencies

The Provider will need to work closely with developmental paediatricians and paediatricians with clinical experience and training in paediatric audiology and appropriate qualifications.

Relevant Clinical Networks and Screening Programmes

In particular the Provider will be dependent on effective working relationships with the NHSP as delivered in South Staffordshire and other elements of the hearing services network.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- Guidelines for surveillance and audio logical monitoring of infants and children following the newborn hearing screen Version 4.2 NHSP November 2010
- NDCS Policy on Audiology Service Provision in the UK July 2011
- Transforming Services for Children with Hearing Difficulty and Their Families A Good Practice Guide DH August 2008
- Quality Standards and Good Practice Guidelines: Transition from paediatric to adult audiology services NDCS November 2011
- Quality Standards in Paediatric Audiology Services – Guidelines for the early identification and audio logical management of children with hearing loss NDCS 2000
- Pushing the Boundaries: Evidence to support the delivery of good practice in audiology. NHS Improvement July 2010
- NHSP Standards and Guidelines – National Programme Centre.
www.hearing.screening.nhs.uk
- Guidelines for the early audio logical assessment and management of babies referred from the newborn hearing screening programme NHSP Clinical Group March 2011
- Map of medicine Care Pathway www.mapofmedicine.com
- Modernised Children's Hearing Aid Services protocols and guidelines.
www.psych-sci.manchester.ac.uk/mchas/
- DH Quality enhancement tool for audiology services
<http://audiology.globalratingscale.com>
- Protocols and guidelines issues by professional bodies as appropriate, i.e. BSA, BAAP and BAA.
- NICE Clinical guidelines CG60 Surgical management of children with otitis media with effusion (OME) February 2008
- Safeguarding policies – www.staffsscb.org.uk

N.B This list is not exhaustive and the provider is contractually obliged to review evidence base on a continual basis.

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

4.3 Applicable local standards

See Section 5

5. Applicable quality requirements and CQUIN goals

5.9	Applicable Quality Requirements (See Schedule 4A-D)
5.10	Applicable CQUIN goals (See Schedule 4E)
6.	Location of Provider Premises
The Provider's Premises are located at:	
7.	Individual Service User Placement

Service Specification No.	MH_20		
Service	Community Paediatrics		
Commissioner Lead	Simon Runnett		
Provider Lead	David Pike		
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			
All current and future legislation and guidance in relation to the delivery of services to children and young people. The service is expected to comply with all local safeguarding policies (adults and children) and respond to any recommendations from Serious Case Reviews, learning reviews and independent Reviews The service will adopt relevant NICE guidance as it is issued. The service will adopt agreed pathways of care as they are developed in partnership with the service and partners.			
2. Outcomes			
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>			
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			
3. Scope			
3.1 Aims and objectives of service			
Aim			
Provide a community paediatric service for medical / health assessments, investigation, treatment and support in the following areas:			
• Child development and neurodisability, • Child public health including immunisation • Safeguarding, child protection and looked after children			
Objectives			
• Work in partnership with other agencies and families to improve outcomes for children and deliver against national and local strategies • Keep children safe from abuse, neglect and accident			

- Promote access to education for all children
- Promote child health and prevent disease
- Provide early recognition and effective support to disabled children
- Effectively and safely manage children as outpatients with medical conditions
- Ensure the medical needs of Looked after children, and those being adopted, are met
- Provide equity and accessibility of service to the vulnerable and hard to reach children

3.2 Service description/care pathway

The Service will provide:

- General community paediatric assessment for children who are thought to have two or more neuro-developmental problems, investigations and diagnosis of children identified as in need of the service. Identification of child's strengths and difficulties and coordination of care packages to meet needs, including concurrent conditions
- Assessment, diagnosis and follow up (of children who meet service criteria) for children in need of protection/in care of the local authority/with special needs
- Engage in Staffordshire Early Help Assessment and Team Around the Child meetings, acting as lead professional where appropriate;
- Management of diurnal enuresis or complicated nocturnal enuresis which has failed to respond to school nursing intervention in line with the primary care pathway;
- Management of encopresis in line with the primary care pathway
- Initiative and support transition planning for young people 14 years upwards
- Urgent child protection medical assessments for children who may have been abused, as part of Section 47 investigations. Coordination with acute providers' access to any medical investigations which may be required.
- Undertake adoption Medicals where South Staffordshire GPs are unable or unwilling to do so and for children known to the service
- Undertake Initial health assessments (IHA'S) for children taken into the care of the local authority, where South Staffordshire GPs are unable or unwilling to do so and for children known to the service.
- Provide the health component of statutory assessments in relation to Education and Healthcare Plans. (EHC).
- Provide advice on health concerns related to safeguarding, adoption and fostering
- Named doctor for roles for Child Protection, Looked-after children and Immunisations
- Provide CCG Designated Doctor for Safeguarding Children for South Staffordshire (see details in appendix a).
- Provide Medical Advisor for Adoption (see details appendix b)
- Provide Community Paediatric Audiology Service (see separate service specification)
- Run evidence-based sleep clinics (in partnership with other providers if appropriate), for children with developmental conditions. Locally developed sleep pathways will be adopted, prescribing of sleep medication will be minimised in line with CPAG requirements.
- Prescribing of medications, as appropriate, for children with developmental conditions.
- Provide relevant assessments as part of the Children and Young People's Continuing Care Assessment Process (Staffordshire/Stoke on Trent Policy), where children known to the service.
- Support in the extension of personal health budgets in line with local and national requirements.
- Ensure all assessments and medicals will be undertaken with due regard to obtaining appropriate and informed consent, confidentiality and child protection/safeguarding policies and procedures.

Community Pediatrician's will work closely with Acute Paediatric Consultants to streamline pathways and align services. They will negotiate with professionals and parents who is best to lead on the care of the child/young person in relation to pathways for:

- Safeguarding
- Looked-after children
- Premature babies
- Epilepsy
- Downs syndrome
- Learning Disability
- Advanced care plans

- Other neurodevelopmental conditions

SEND

The service will engage with other agencies (including education and social care) and parents/carers/children & young people in the delivery of services related to special educational needs (SEND). This will include contributing to the health elements of EHCPs & updating the Local Offer in line with any changes in the provision of this service.

With reference to the local offer, the service will ensure that they are registered, and their service offer is detailed on the Staffordshire Local Offer website within the Staffordshire Marketplace, in accordance with the special educational needs and disability code of practice 0-25 years. Details of how to register can be found at:

<http://helpyourself.staffordshirecares.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

The service will ensure that their service offer is kept current and up to date. Support can be accessed through The Designated Clinical Officer representing the CCGs.

Safeguarding

The provider is expected to work in line with current safeguarding policies & procedures as detailed by the local safeguarding board & national guidance. (Working together to Safeguard Children 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

As appropriate adult safeguarding procedures should be adhered to in all cases.

Chaperone Policy

The provider will have appropriate chaperone policies aligned to current national

guidance:https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

Was Not Brought Policy

The provider will have a policy in place to replace DNA policies to address any concerns regarding children & young people not being brought to medical appointments:

https://seriouscasereviews.rip.org.uk/wp-content/uploads/LSCB_SCR_Briefing_v2.pdf

3.3 Population covered

Geographic coverage/boundaries

The Service will be available to children and young people up to the age of 18 years who are the commissioning responsibility of one of the four CCGs located in South Staffordshire.

NB Young People aged between 16 and 18 years will be managed through either community paediatrics or adult services, as appropriate and accepted to age appropriateness and individual need, however all young people of this age will be offered a service.

Days/Hours of operation and Response Times

The Service will operate flexibly within normal working hours (as defined in national medical contracts) for the majority of its services. Child Protection medicals Mon – Friday normal working week 9-5 (Bank Holidays excluded) in line with pathway agreed with acute hospitals

The Service will meet the following response times:

- Child protection medicals - same or next working day
- Initial health assessment - to be completed within 10 working days of receipt of referral and all necessary records / paperwork from SSOTP as per IHA pathway (agreed 2013)

18 week referral to treatment pathway will apply to all other referrals.

Priority Referrals

Community Paediatric Service will prioritise referrals as follows:

- Child protection medicals (in hours)
- Initial/review health assessments on Children in Care/Looked after Children

- Adoption medicals

Referral route

Referrals will be accepted from

- General Practice
- School Nurses
- Health Visitors
- Acute Pediatricians
- Other Health Professionals
- First Response
- Police
- Special Educational Needs Coordinators (utilising standard referral form)
- Audiology
- CAMHS
- ASD service providers

3.4 Any acceptance and exclusion criteria and thresholds

Young People over 18 years of age or living outside of South Staffordshire who are not registered with a South Staffordshire GP.

For Children/Young People who are placed in South Staffordshire from another CCG area – responsible commissioner guidance will be followed, and funding sought from host CCG.

3.5 Interdependence with other services/providers

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Response time & detail and prioritization

The Service will meet the following response times:

- Child protection medicals - same or next working day
- Initial health assessment - to be completed within 10 working days of receipt of referral and all necessary records / paperwork from SSOTP as per IHA pathway (agreed 2013)
- 18-week referral to treatment pathway will apply to all other referrals.

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

NICE

- PH3 - Prevention of sexually transmitted infections and under 18 conceptions
- PH4 - Interventions to reduce substance misuse among vulnerable young people
- PH6 - Behaviour change at population, community and individual level
- PH7 – Alcohol and Schools
- PH8 - Physical activity and the environment
- PH9 - Community engagement
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH20 – Promoting young people's social and emotional wellbeing in Secondary Education
- PH21 – Reducing differences in uptake in immunisations
- PH23 – School based interventions to prevent smoking
- PH24 Alcohol-use disorders: preventing harmful drinking
- PH26 - Quitting in smoking in pregnancy and following childbirth

- PH27 - Weight management before, during and after pregnancy
- PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued
- PH30 Preventing unintentional injuries among the under-15s in the home
- PH31 Preventing unintentional road injuries among under-15s
- PH40 Social and emotional wellbeing – early years
- PH42- Obesity working with local communities
- PH44 Physical activity: brief advice for adults in primary care
- PH46 Assessing body mass index and waist circumference thresholds for intervening to prevent ill health a premature death among adults from black, Asian and other minority ethnic groups in the UK.
- PH47 - Overweight and obese children and young people - lifestyle weight management services
- PH48 - Smoking cessation - acute, maternity and mental health services
- PH49 Behaviour change: individual approaches
- PH50 - Domestic violence and abuse - identification and prevention
- PH51 - Contraceptive services with a focus on young people up to the age of 25

NICE Quality Standards

- QS22 Quality standards for antenatal care
- QS31 Quality standard for the health and wellbeing of looked-after children and young people
- QS34 Self Harm
- QS36 Urinary tract infections in children
- QS37 Postnatal Care
- QS39 Attention deficit hyperactivity disorder
- QS42 - Headaches in young people and adults
- QS43 Smoking cessation: supporting people to stop smoking
- QS46 Multiple pregnancies
- QS48 Depression in children and young people
- QS51 – Autism
- QS55 - Children and young people with cancer
- TA102 - Conduct disorder in children - parent-training/education programmes
- National Health Visiting Programme: supporting implementation of the new service model pathways
- No. 1: Health visiting and midwifery partnership – pathway for pregnancy and early weeks
- No. 2: School nursing and health visiting partnership
- No.3: Maternal mental Health
- No.5: Safeguarding

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Location(s) of Service Delivery

The Service is locality and community focussed and therefore should be delivered from appropriate locations and within suitable settings, including appropriate multi-agency community settings and the service user's home/place of residence when necessary.

7. Individual Service User Placement

N/A

Service Specification No.	MH_21
Service	Community Complex Care Team (CCCT)
Commissioner Lead	Nicky Bromage
Provider Lead	Claire Bailey, Children and Families, Midlands Partnership Foundation Trust (MPFT)
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

Policy context

- Department of Health, 2018 “National Service Framework for NHS continuing healthcare and NHS funded care”.
- DoH NSF for children, young people and maternity which specifically covers children with complex disability–2004 & 2005.
- DoH - Better care: better lives. Improving outcomes and experiences for children, young people and their families living with life limiting & life-threatening conditions – 2008.
- DoH National Framework for Children and Young People’s Continuing Care 2016

Local strategic context

- Coventry & Warwickshire Children & Young Peoples Interactive Competency Framework
- West Midlands Quality Review Long Term Ventilation Standards 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

Expected Outcomes for Service Users

- Children, young people and adults with complex needs cared for safely in their home (Domain 2,3,4,5)
- Availability of identified Complex Care Nurse and/or On Call Nurse (Domain 2,3,4,5)
- Weekly assessments/reviews by the Complex Care Nurse (Domain 2,3,4,5)
- Appropriate training provided to parents and carers of children and adults with complex needs, including at least annual updates/multidisciplinary meetings or as required, according to the needs of individual cases (Domain: 1,2,3,4,5). Additional to training provided by routinely commissioned services (universal/specialist)

- Personal Health Care Plan and Risk Assessment devised and reviewed regularly (Domain 4,5)
- Emergency Health Care Plan at the point of discharge, agreed by the MDT and shared with community professionals and parents (Domain: 2,3,4)
- Transferable health care plans to be written for care of children, young people and adults with complex needs in the acute hospital setting, in accordance with individually agreed transfer of the home care package support into the hospital setting only
- Follow up plan for every patient, agreed at each multi-disciplinary team meeting (Domain: 2,3,4,5,)
- Where they wish to do so, patients are provided with end of life care to enable them to die at home (Domain 2,4,5)
- Improved patient and carer satisfaction (Domain 1,2,3,4,5)
- Parents and carers are supported to care for their children in their own home (Domain 2,,4,5)
- Patients are supported in developing self-care abilities (Domain1,2,4)
- Effective transition to adult services (Domain 2,4)
- Liaison and collaborative working with multi-agencies to ensure best outcomes are achieved

3. Scope

3.1 Aims and objectives of service

Service Objectives:

- To ensure children and adults with complex needs are cared for safely in their own home.
- To ensure risks are minimised through education and training of support workers and parents/guardians.
- To facilitate a timely and safe discharge from secondary care.
- Provide comprehensive care plans in conjunction with other health, social care and educational professionals in order to ensure a holistic seamless delivery of care.
- To facilitate a robust pathway of transition to adult services for those patients who continue to require one to one support.
- To work in an integrated way with acute and community services.
- Avoid unnecessary admissions and attendance to secondary care.
- Work in partnership with children and their families, and partner agencies.
- Provide early identification of health needs in children and adults who are on the caseload, offering appropriate advice and support and referral onwards as required including arrangement of direct admission for patients when required.
- Work closely with commissioners providing updates and feedback as necessary.
- Encourage children, young people and adults with complex needs to gain control of their care including guidance regarding personal budget options for the delivery of health care services.
- To be responsible for the procurement, management and maintenance of patient held equipment via the Clinical Commissioning Group responsible for the patient.

3.2 Service description/care pathway

All referrals to the service currently come direct from children or adult commissioners via email. However, Personal Health Budgets may see direct referrals to the service, on behalf of the child/young person or adult who has eligibility for Continuing Care/Continuing Health Care (CHC) respectively. Direct liaison will occur between the Community Complex Care Team (CCCT) and the Personal Health Budget Lead with regards to the nature and complexity of work which is to be performed by the Midlands and Partnership NHS Foundation Trust (MPFT) CCCT for individuals who are Continuing Care/Continuing Healthcare eligible, and have chosen to have a Personal health Budget for their care delivery.

The service assesses the healthcare needs of individuals and works in conjunction with other members of the multi-disciplinary healthcare team, education and social care to ensure the patient and family's care needs are appropriately and safely met. The Community Complex Care Team will ensure that care is co-ordinated and formal agreements are in place between all agencies involved in the patients care (to include parents and families), agreeing roles and responsibilities and expectations.

Packages will be funded on a case by case basis in agreement with commissioners. The current service infrastructure is commissioned for 18 packages. MPFT CCCT 18/19 management costs as per agreement with Commissioners providing management for 18 care packages. These costs are pro-rated and dependent upon the number of care packages and should not include third party or direct payment PHBs. Any PHB management costs will be included within the individual PHB financial arrangements and shall be separate of the '18' cases management costs.

It takes approximately 3-6 months for CCCT to set up a care-package, this ensures that parents and family members are trained and prepared to take responsibility for the patient and allows time for recruitment and training of staff. CCCT will not charge for the full care-package until all staff are in post, costs will be claimed for as individual staff members commence employment. If CCCT subcontracts out to support packages the cost will remain with MPFT.

All care packages are frequently reviewed by the service to ensure they meet the needs of the patient; in the event that the patients clinical condition improves or deteriorates the CCCT will liaise with commissioners and social care to ensure that the package of care is reviewed in a timely manner. Reviews will be undertaken to monitor the case management allocation and adjusted following agreement with the Continuing Health Care Assessor.

CCCT, as able, will support patients to go on holiday. At least four months' notice needs to be given to CCCT in order to discuss with staff and arrange shifts accordingly. This support cannot be guaranteed but all efforts will be made to accommodate and facilitate patients' requests. If extra care is needed to support a holiday further discussion will need to be had between CCCT and the commissioners and social care.

In the event that an individual no longer requires care from CCCT, the service will be given 3 months' notice by the commissioners that funding will cease. This allows the service to look for alternative employment for any affected team members, ensuring retention of their skills and avoidance of redundancy costs. Any decrease in a care package will also require a maximum of a 3-month notice period, during the 3 months' notice period costs to be reflective of the decrease in the care being delivered. If redeployment occurs as a result in the facilitation of a new CYP care package set up or recruitment into an existing CYP care package, or vacancy within the totality of the organisation there will be no charge during the notice period for that element of the package (as the costs for any new or existing care package will be costed in accordance with those individual care packages). CCCT to provide CHC with the details of staff re-deployment date within the 3-month notice period to ascertain cessation of costs for individual staff members. If redeployment to a new or existing CYP care package, or within the totality of the organisation is not an option, a shared risk of 6 weeks will be applied following discussions between CCCT and the lead commissioner of MLCSU and CCG. Shared risk to be enforced only in respect of the non- deployment of permanent members of staff with a substantive contract. In the case of individuals funding arrangements that are managed under a Personal Health Budget notice will be served at an appropriate time in accordance with the withdrawal of support/ phased withdrawal of care.

An 'on- call' service will be provided by the CCCT, there will be a qualified nurse available at all times to deal with any queries raised by staff/ individuals or families regarding care provision. The on-call service is not designed for use in an emergency but does operate 24hours a day 7 days a week, for those care packages that are assessed as requiring this type of support.

In the event of a significant change in the Service User's needs or if the requirements of the existing Care Plan change significantly, that requires a change in the service provision (a decrease or increase), the Provider shall notify the Commissioner as soon as is reasonably

practicable and if in the case of an increase in needs the provider shall take any immediate necessary action in order to ensure the safety of the Service User. Any requirement for increased support (1:1 or 2:1 etc.) must be notified within 24 hours to the CHC department and pending review of all the evidence of reassessment and rationale to support the need for additional support, approval of funding shall be backdated to the date of the initial request. Whereby the provider has not informed the CHC department of a change where there is an improvement in the service user's condition, the Commissioners are entitled to reclaim to the date the improvement is documented.

A further Nursing Assessment shall be undertaken by the CHC department (on behalf of Commissioners) as soon as is possible after the date of request, including referrals to Health and Social Care professionals for the assessment and/ or treatment for the Service User.

Care Planning

- Plan of care to be agreed with the patient/parent/carer and multi-agency partners (where necessary) who are involved with the service user.
- Letters will be sent to General Practitioner and parent/carer and other healthcare professionals as appropriate to ensure good levels of communication are maintained.
- Patients and packages of care will be case managed to ensure good coordination of care, referring patients as appropriate and in line with agreed pathways of care.
- Assessment and care plans for patients to be developed in partnership with family and partners, for all patients who are referred to the service.
- Agree clear management plan based on evidence and informed by protocols, guidelines and pathways.
- Attend multidisciplinary meetings both in primary and secondary care.
- To act as lead professional/key worker as appropriate.
- Promote and support self-care.
- Assessment and management of pressure areas at home.
- Monitor and ensure appropriate pain control throughout assessment and intervention.
- Ensure patients, parents and carers have clear contact points for accessing support.
- To work with and development new clinical and multi-agency pathways, including integrated care pathways.
- Support and contribute to SEN assessment and care management approach.
- Support Continuing Care team in the assessment of needs for funding requests. Complete appropriate section of the Decision Support Tool (DST) for children with continuing care needs.

Secondary Care

- CCCT will provide care where a patient is admitted into secondary care- based upon individual assessments in accordance with individual agreements
- CCCT staff will attend a patient in secondary care for training purposes and to facilitate an early discharge if the care staff require additional training to care for the child, young person or adult, as per individual agreements
- CCCT must have honorary contracts in place in order for staff to carry out healthcare interventions within the secondary setting, in accordance with agreements made between CHC commissioners and MPFT CCCT

Palliative care/end of life care

- Agree and support a plan for end of life care
- Facilitate maintenance of the child in the home environment and to provide end of life care for children/young people within the home environment, wherever possible.
- Involvement in pain management and symptom control
- Liaise with other services/professionals as required
- Access continuing care funding to provider 24-hour support, as required. Following Continuing Care funding protocols, as appropriate

Transition:

- Facilitation of transition of patients on the caseload from paediatric services to adult services.

- To develop interagency transition pathways with other partner agencies and to work to interagency pathways as they are developed in Staffordshire.
- Protocols to take into account the maturity of the young person and allow for flexibility and scope for choice
- Protocols to take account of policies and guidance from Staffordshire Local Children's Safeguarding Board (LSCB) and vulnerable adults safeguarding policy

Special Educational Needs

- To advise and support children, young people and their carers regarding the revised arrangements for the assessment and provision of SEN support
- To provide assessments required by the EHC planning process within the required timescales.
- To participate in assessment and planning as part of the EHC process.

Training

- To provide or support training for families/ PAs/TAs and healthcare staff from partner agencies on caring for children with specific nursing needs who are currently known to the service in respect of traditional commissioned packages or Notional PHBs
- The service will provide additional training for partner agencies for cases not on the caseload, where it is funded by the partner agency.
- CCCT will provide all necessary training to care workers, ensuring competencies relevant to training are completed, and care workers are safe and competent in carrying out health interventions
- CCCT may need to purchase external training programmes which meet the needs of individual children, young people or adults; costs will be discussed and negotiated with the relevant lead health commissioner within MLCSU/CCG

CCCT will access training delivered by routinely commissioned services (universal and specialist) as necessary but must not deliver any training thereafter that should be provided by routinely commissioned services.

3.3 Population covered

Any patient whose Responsible Commissioner is any of the 6 Staffordshire CCGs.

3.4 Any acceptance and exclusion criteria and thresholds

Exclusion of complex mental health needs.

3.5 Interdependence with other services/providers

The service will work collaboratively with any other provider or agency involved in the care of the child/young person as required. CCCT will not substitute any routinely commissioned NHS service.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All NICE guidelines and Guidelines affecting children

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

4.3 Applicable local standards

All Trust policies and procedures

5. Applicable quality requirements

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider premises
Block 6, Ground Floor, Georges Hospital, Corporation Street, Stafford, ST16 3AG Block 6, St Michael's Court, Trent Valley Road, Lichfield, Staffordshire, WS13 6EF Hanford Health Centre, New Inn Lane, Hanford, Stoke-on-Trent, ST4 8EX
7. Individual Service User Placement
At the commencement of a funding arrangement a Service Agreement shall be raised by the CHC which shall be specific to each Individual Service User. This shall be signed by both parties.

Service Specification No.	MH_22
Service	Individual Placement and Support (IPS) Wave 1
Commissioner Lead	Nicola Bromage
Provider Lead	Lisa Agell
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 NHS England intends to distribute funding to support the expansion of IPS in two targeted waves: • Commencing 2018/19: Wave 1: Expansion at pace within an STP area that already have established IPS services; • Commencing 2019/20: Wave 2: Increasing provision in STP areas that do not have any IPS service provision. This service expansion falls under Wave 1 Transformation Funding. Submission for funding made by the Staffordshire and Stoke on Trent STP on behalf of the following parties: • Stoke on Trent CCG • North Staffordshire CCG • Stafford and Surrounds CCG • Cannock Chase CCG • East Staffs CCG • South East Staffs and Seisdon Peninsula CCG • North Staffordshire Combined Healthcare NHS Trust • Midlands Partnership Foundation Trust (previously SSSFT) • Staffordshire County Council • Stoke City Council • Health and Employment Partnerships • Staffordshire Employment Service Existing provision There are 2 IPS providers that are accredited Centres of Excellence in Staffordshire, 'Step On' covering Stoke on Trent and the Staffordshire Employment Service (Making Space) currently covering the whole of Staffordshire. This pre-existing IPS development reflects the wider strategic prioritisation of improving employment opportunities for people marginalised from the labour market in Staffordshire and Stoke on Trent. This proposal comes from an area with considerable experience of, and enthusiasm for, IPS alongside strategic support from commissioners and organisational commitment from Secondary Care Mental Health Trusts that provides a structure for successful implementation of increasing access to IPS. Step On team overview The Step On team has been operational since March 2013 when they were part of the Improve project across the West Midlands. This project saw a number of teams through a development process supported by 'Enable' and the Centre for Mental Health to deliver Individual Placement and Support (IPS) with fidelity to the IPS model; Step On had their fidelity review in September that year and became a centre of excellence. They continue to be a centre of excellence following their review in 2016.	

The Step On team delivers an IPS service to service users accessing North Staffordshire Combined Healthcare NHS Trust (NSCHT). It is delivered through NSCHT and funded by the Section 75 agreement with Stoke-on-Trent local authority.

The service is targeted at those service users receiving care within NSCHT that are resident in Stoke on Trent. 60 referrals were received from secondary care in 16/17.

Proposal for how funding will be used

The County of Staffordshire, including Stoke on Trent, is large, comprising a mixture of rural and urban areas. There is one Unitary Authority (Stoke on Trent); a County Council with 8 District / Borough Councils and 6 Clinical Commissioning Groups. Boundaries are not co-terminus, thus the blended model of IPS providers gives the greatest opportunity to expand and increase access to IPS.

The proposed model will build upon the 'Step On' service and extend its reach into geographical areas of south Staffordshire.

The 'Step On' service shall have both NSCHT employed Employment Specialists and Peer Workers and MPFT employed Employment Specialists and Peer Workers to ensure there is full clinical integration and access to electronic records.

All current and newly recruited employment specialists shall receive the required training from the centre for mental health to ensure fidelity to the model; this would include, "Doing What Works - Implementing a successful IPS service", Engaging with Employers and Motivational Interviewing.

The 'Step On' service would have, at its centre, the necessity to provide fidelity to the core principles of IPS. Having had the experience of starting a team from the beginning to delivering a service that has been assessed as having exemplary fidelity; IPS only works when the model is implemented fully.

People Securing Paid Employment

Evidence from the performance of both the IPS service in Staffordshire and Stoke on Trent suggests that between 30% and 40% of those individuals engaged with the service will go on to secure paid employment. Thus in 2018/19 it is expected that expect between 123-164 people and in 2019/20 between 158-210 people in contact with secondary care mental health services to secure paid employment.

Work is good for mental health, and poor mental health can be the reason for people becoming unemployed. Evidence suggests that being out of work for long periods is generally bad for your health, resulting in: more consultations; higher use of medication and higher hospital admission rates than for the average population. However, people with a mental illness find it hard to access the workplace, and the workplace itself can be stressful and impact on the wellbeing of individuals.

Employment not only has economic benefits, but it also gives people a sense of self-worth: the longer someone is out of work the harder it is to re-join the job market – early intervention applies equally to treatment and care services for mental illness as to prevention.

Targeted employment support for people recovering from mental illness assists recovery and reduces the demand for care services.

For those with mental health problems, being employed can be an important step to recovery, improving self-esteem and confidence and reducing psychological distress.

Employment is therefore vital for maintaining good mental health and promoting recovery from mental health problems. Work is often part of treatment and getting back to work is part of the recovery process.

Evidence shows strongly positive cost/benefit of IPS:

- Supporting an individual into work generates savings on out-of-work / means-tested benefits, tax credits, and tax receipts
- Additional savings likely to accrue to health service; IPS reduces health service use: fewer days in hospital, reduced rates of readmission (Hoffman, 2014)
- Significant saving if someone with severe mental illness does not relapse
- Economic studies estimate £1.59 saving for every £1 spent (Van Stolk, 2014)

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

Individuals with complex mental health conditions to gain employment and remain in employment in line with the aims of the Five Year Forward view which states that by 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

3. Scope

3.1 Aims and objectives of service

To support service users in achieving and maintaining paid employment, building on an individual's recovery and aspirations for the future.

IPS is an approach which uses a 'place and train' model based on the following 8 evidence based principles:

1. Eligibility is based on individual choice – no exclusions
2. Employment support is integrated with treatment
3. Competitive employment is the goal
4. Rapid job search (within 4 weeks)
5. Job finding, and all assistance, is individualised
6. Employers approached with the needs of individuals in mind
7. Follow-along (in work) supports are continuous
8. Financial planning is provided

IPS service should be available to all who wish to work and would wish to expand the provision to target specific groups, to open up pathways and increase life chances.

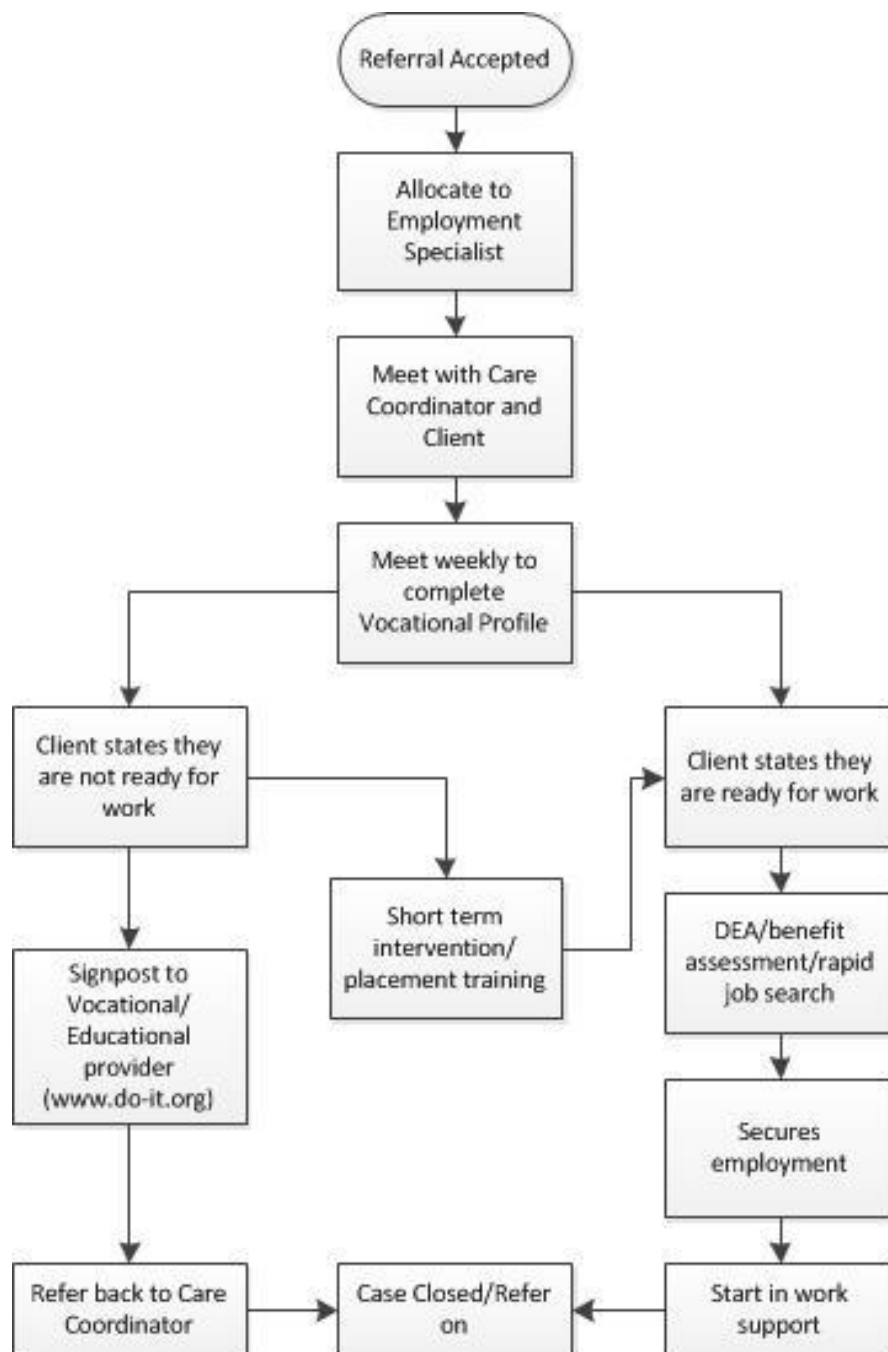
The aim would be to work within services to understand the needs of service users within the groups identified and increase opportunity and access to IPS. The initial targeted groups would be:

- Veterans
- BAME
- Early Intervention in Psychosis
- LGBTQ

The recruitment process will be inclusive with the addition of peer workers to help engage and widen participation for under-represented groups.

The team facilitate a quarterly Vocational Forum held at Hanley Jobcentre which covers the North Staffs and Stoke on Trent localities. As part of the programme expansion this shall be replicated across South Staffordshire.

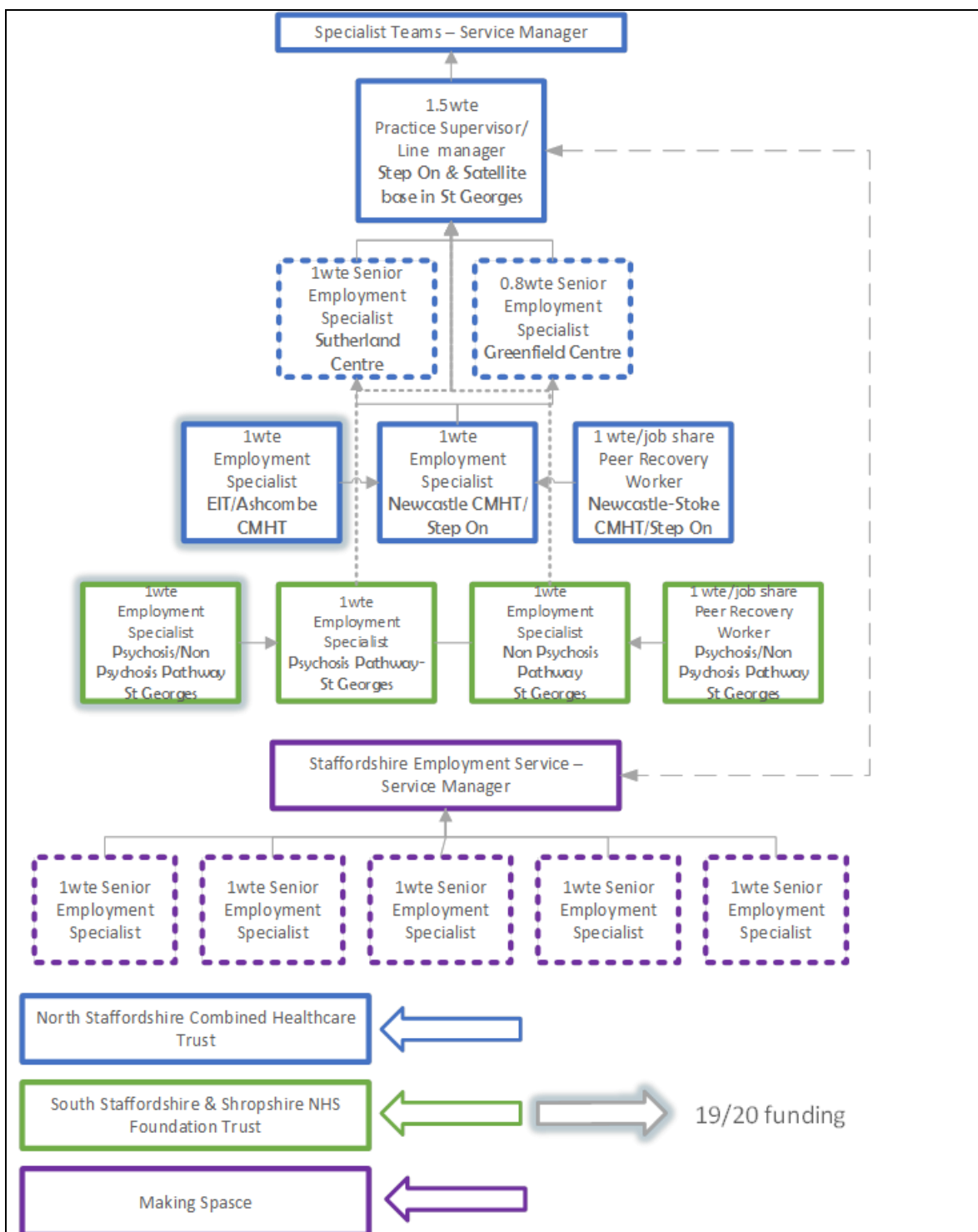
3.2 Service description/care pathway



IPS is an evidence based “place then train” model, meaning specialists help clients get a job as quickly as possible, and then support them for an extended period to sustain their employment. It operates with low caseloads (20-25 people), allowing specialists to provide intensive, individualised support.

The service would expect that the average duration from referral to employment would be between 4 and 5 months, noting that the majority of employment outcomes are achieved within the first 6 months of intervention.

Staffing Model



Making Space Staffordshire Employment Service (no longer in existence) shown above is now 3wte employment advisors and the resource has transferred to MPFT.

Staffing is fundamental to successfully increasing access to IPS and needs to involve, swift recruitment, skilled staff, IPS competencies and appropriate support and supervision.

Investment will be phased over the two-year period to support the delivery of the increased referrals. Initial work will need to be done within CMHTs to raise awareness and understanding of IPS and the positive impacts the service can have. The use of peer workers will be an innovation within teams to support the delivery of the IPS model.

Vocational Peer Support Workers

The expansion of the service will also include the establishment of specialist vocational peer support workers. It is the intention to recruit individuals from a diverse range of backgrounds such as BAME and LGBTQ. The potential work programme for these workers is detailed in the bid document included in Schedule 5.

The Peer Support role will work in a fully integrated way based in secondary care clinical mental health teams to provide high quality peer support and to promote user involvement, user empowerment and self-management among people with mental health needs. It is intended the vocational peer support workers will be part of a wider Pan Staffordshire peer support network, linking in for example with Peer workers in the Criminal Justice teams and established Peer workers in MPFT's pathways. It is expected average caseload per whole time equivalent will be 16 individuals alongside group work capacity.

There is an acknowledgement that recruitment will be a process and training will be required to support the new employment specialists to develop the necessary IPS skills.

Stages of delivery:

Proposal envisages three high level stages:

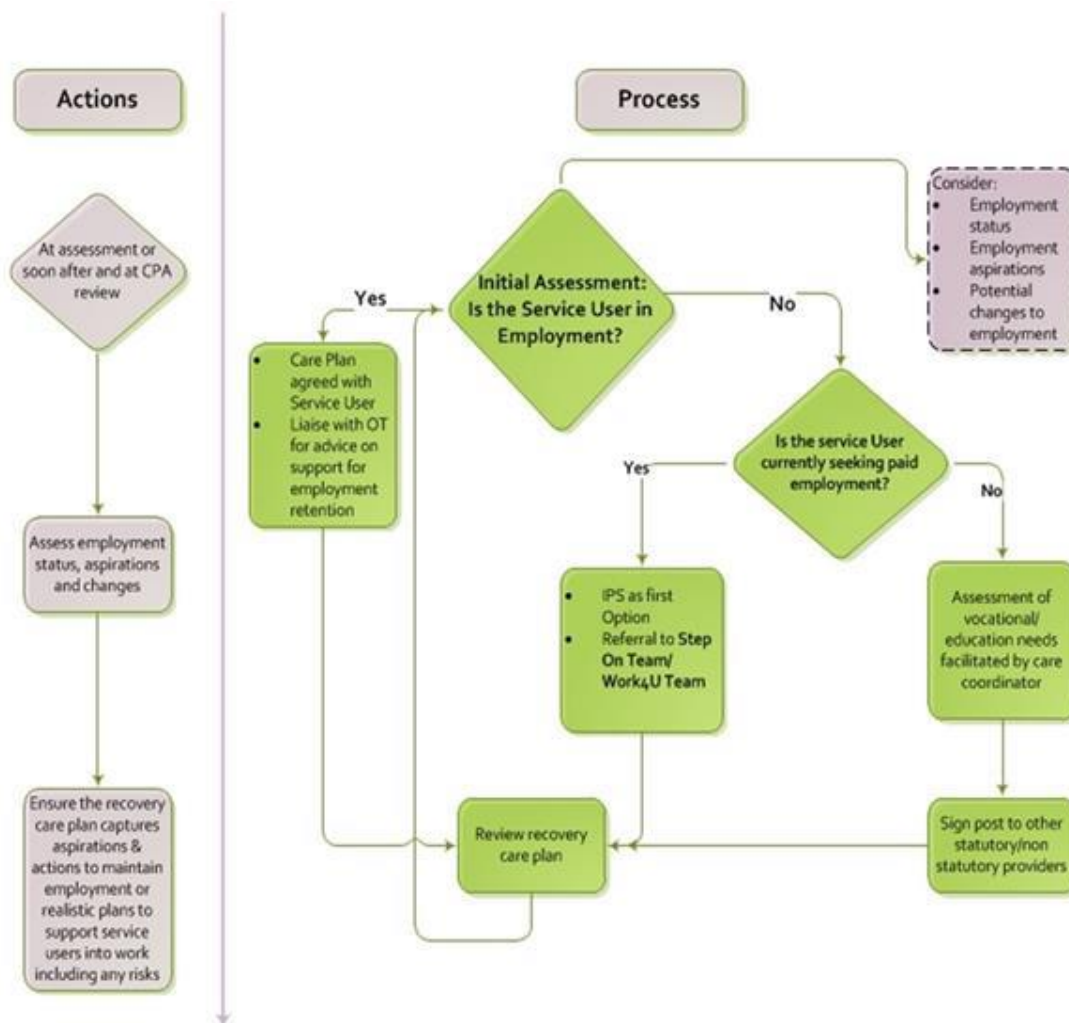
- **Start Up.** In which the governance arrangements will be established, the team and wider network will be established and supported to form key relationships; and systems for measuring and evaluation will be established including clarification of baseline data.
- **Delivery and Learning.** This is the main stage of delivery in which the services will be provided and the ways of working will be incrementally enhanced to reflect the learning and feedback from service users. Within the service delivery itself there will be a phased approach to reflect the complex nature of the arrangements which are required.
- **Sustaining Progress.** In which impact will be evaluated and key decisions taken regarding the future provision of IPS mental health services

The mental health trusts are invested in ensuring service users have access to IPS services. The new model employs staff as part of the trust who will sit within the CMHT they are working with, use the same electronic patient record, attend the team meetings and feedback their outcomes to support them and to raise understanding.

The staffing identifies both the need to embed workers within teams but also the need for the development of the team along IPS core principles. All staff recruited will receive accredited training through the Centre for Mental Health including the core IPS training, employer engagement training and Motivational Interviewing training. The key to any service that wants to embed evidenced based practice is not just the training but the level of specialist supervision. As skills are acquired they can soon become rusty without constant use and the appropriate level of supervision.

The oversight and management of the existing centre of excellence in Stoke on Trent will ensure that there are clear pathways from the point of referral into services to understand people's vocational status and to appropriately refer into IPS services.

Integrated Service User Employment Pathway:



The pathway will be shared and reviewed within teams to ensure they are sensitised to vocational issues and the support available to service users.

When a person is accepted into either IPS service, the Employment Specialist will have an early joint meeting with the customer and care coordinator leading to a full vocational assessment. This will identify personal strengths, skills including job preferences and any potential work barriers.

The Employment Specialist will support the customer to build an up to date Curriculum Vitae (CV) that will then be uploaded to a Government Gateway account on the Universal Job match site. Following this the worker will complete a rapid job search and begin employer engagement with potential referral into partnership agencies if needed. There will be on-going support with completing applications, contacting employers to search for potential vacancies with interview skills and techniques coaching. This prepares people to enter the workplace and to foster belief in themselves allowing them to explore different ways of tackling the interview process.

The Employment Specialist actively supports the customer to prepare for work which can include flexible working, the access to work scheme and supports strategies to maintain mental wellbeing whilst in the work place e.g. Wellness Recovery Action Plan (WRAP).

When the individual starts paid employment the worker will maintain regular contact through mutually agreed means thus ensuring the person has effective coping strategies

to manage potential workplace stress.

Workforce Development:

Recruitment will be phased over 18/19 and 19/20 to respond to the trajectory with approximately half the staff being appointed in each financial year. It will be essential to appoint a supervisor/manager initially to be involved at the earliest stage to support recruitment. The supervisor will have experience of IPS and a professional qualification, to be able to take a hands on approach to the development of staff across the localities.

The recruitment will target both experienced mental health support workers looking for development with transferrable skills to be an employment specialist, and potential work coaches who are looking to develop their skills in mental health. There is potentially a small number with the necessary existing skill set so there is a need to factor in training and development from both an IPS perspective but also core mental health skills.

All employment specialists will receive the core training as mentioned. The existing service will provide shadowing and mentoring to new staff to develop the employment specialist to understand all the IPS core principles and how this translates into practice.

The peer workers will be potentially recruited through Step On and be open to existing service users with the skills and motivation to develop as a peer. The team have strong links with Changes a local mental health charity that has existing peer workers who also will be eligible to apply. South Staffordshire has an existing peer worker pathway and development opportunities that the peer worker will be involved and supported through.

STP are exploring peer development training that would provide a framework to enable them to helpfully use their recovery journey to support others and also maintain their health and wellbeing.

3.3 Population covered

Individuals registered with a GP located within the boundaries of the 6 Staffordshire Clinical Commissioning Groups (North Staffordshire CCG, Stoke on Trent CCG, Stafford and Surrounds CCG, Cannock Chase CCG, South East and Seisdon CCG and East Staffordshire CCG).

3.4 Any acceptance and exclusion criteria and thresholds

The referral criteria that is operated across all providers is that any person who expresses a wish or desire to secure paid employment and is in contact with secondary care mental health services is eligible to use the service. The individual must be willing to work. This will initially be tested by their clinician, since employment should be part of the service user's recovery plan.

However, their willingness may also be tested by the IPS team if they feel a clinician has "pushed" an individual to their services. This criteria is the only exclusion criteria embedded in the IPS core principles.

As long as the person is actively engaged in the service and wants to secure paid employment, they can access the service as long as they require. This is to ensure there is no 'cherry picking' of clients and the services continue to work with a range of individuals including those who are furthest away from the job market as a result of long periods of worklessness or criminal convictions or legal restrictions placed on them. IPS services operate a "zero exclusion" policy, which means they do not reject service users based on the severity of their condition, their skills, employment history, or any other criteria other than willingness to work.

3.5 Interdependence with other services/providers

The service model embeds services within clinical teams, a core requirement of the IPS model but also an existing challenge to services. The staff will be employed through the mental health trusts (NSCHT & MPFT) with staff in South Staffordshire being managed and supervised by the Step On service to ensure that the developing services have fidelity to the model with a view to the whole service being assessed through the Centre for Mental Health to be a centre of excellence. Both IPS' teams have regular meetings with Jobcentre Plus (JCP) and have close links with local businesses. This specific involvement increases the opportunities and helps service users' transition through JCP and into the work arena. Staffordshire and Stoke on Trent STP recognises the importance of working with employers and businesses to reduce the stigma associated with poor mental health and developed a resource www.howsyourbusinessfeeling.org.uk. This interactive self-assessment and training resource helps managers and organisations to create a mentally healthy workplace that is inclusive and supportive of people with experience of mental health problems. The IPS services are part of a commissioned pathway of care across Staffordshire and Stoke on Trent for individuals with mental health needs including prevention; care, treatment and support; and employment and mainstream options. Social Care and the CCG's jointly commission Mental Health Social Inclusion and Recovery services (MHSIR) delivered by third sector partners such as Rethink, Making Space, and Together for Mental Wellbeing for people who are in contact with Mental Health Secondary Care services. The MHSIR services are focused on raising people's aspirations and achieving their goals and promoting independence building on people's assets by taking an outcomes focused approach. If people are not quite ready for paid employment through the IPS services, these services work with individuals to develop their vocational skills through volunteering or training and educational placements. As soon as a person is the ready to seek paid employment they can then be referred to the IPS pathway. This pathway between IPS and the MHSIR services ensures people are accessing the right support for their needs and aspirations at the right time allowing for flexibility between the services depending on where they are with paid employment goals. This is demonstrated in the 'Integrated Service User Employment Pathway' in Section 4 where vocational aspirations are assessed and service users are directed appropriately based on their needs. It is recognised that volunteering can be an important step towards employment. Both MH trusts have active volunteer programmes that support service users to develop their potential and skills for employment; resources such as www.doit.org provide a wide range of local opportunities prior to service users entering the IPS pathway.	
4.	Applicable Service Standards
4.1	Applicable national standards (eg NICE) Not applicable
4.2	Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges) Not applicable
4.3	Applicable local standards Not applicable
5.	Applicable quality requirements and CQUIN goals
5.1	Applicable Quality Requirements (See Schedule 4A-C)
5.2	Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises
The Provider's Premises are located at: The service is embedded within practice having an office base with the early Intervention Team and practice time within the Community Mental Health Teams.

Service Specification No.	MH_23
Service	Severe Mental Illness - Mental & Physical Health Checks (MPHC)
Commissioner Lead	Mel Mahon
Provider Lead	General Practice & Midlands Partnership Foundation Trust
Period	1st October 2019 – 31st March 2023 The First 12 months of the agreement will be a pilot phase to get a clearer understanding of the operating model and the impact on assessments.
Date of Review	By 31 st March 2023

1. Population Needs

1.2 National/local context and evidence base

1.2.1 Compared to the general population, individuals with SMI (such as schizophrenia or bipolar disorder):

- Face a shorter life expectancy by an average of 15–20 years.
- Are three times more likely to smoke.
- Are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream).

1.2.2 In Staffordshire we have approximately 7600 people registered with GP practices experiencing a severe mental illness, approximately 1200 are open to secondary mental health services in South Staffordshire. These patients will either:

- Have their physical health and mental health monitored entirely in primary care.
- Have their physical health and mental health monitored in secondary mental health services.
- Have their physical health and mental health monitored in a mixture of both primary care and mental health services, sometimes duplicated and sometimes without clarity of responsibility.
- Not always be receiving a physical or mental health review.

4.3 As a health system we need to commission a model that ensures everyone receives an annual physical and mental health review, with no ambiguity of who is doing what and when

2. Outcomes

4.4 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

- Increase in the number of patients receiving a physical health check from 30% to a minimum of 60%
- Detection of cardio-metabolic health risks
- All people attending a review will receive health promotion brief advice on reducing cardio-metabolic risks: smoking, alcohol, diet and exercise
- Detection of deteriorating mental health in the group of people not actively receiving interventions from mental health services
- All people attending the joint review with an identified mental health or cardio-metabolic health problem or risk will be offered signposting advice or supported to access appropriate services.
- Identify opportunities for medication reduction when prescribed for mental health and cardio metabolic difficulties
- All people attending a joint review will have receive a summary of the review; including any agreed actions.
- Streamline patient pathways and encourage integration with secondary care providers
- All patient experiences of the joint reviews are reported as positive

3. Scope

3.1 Aims and objectives of service

- 3.1.1 Everyone with a severe mental illness in Staffordshire shall offered an annual physical and mental health review, regardless of which service/s they are receiving care from.
- Include providing; advice, intervention and signposting required following a review (physical, mental and social).
 - An information sharing pathway, in the absence of a digital solution.
 - Develop knowledge and skill of primary care staff in working with people with severe mental illness.
 - As a result of the joint reviews people will have fewer undetected health risks
 - People with a severe mental illness will not remain on medication longer than is necessary.
 - The long term the average life span and quality of life for this group of people will improve.

4.5 Service description/care pathway

- 3.2.1 The Provider shall undertake a physical health check which will be made up of the following elements (appendix 2 outlines the full reporting requirements that will be reported via the primary care clinical systems):

Physical Health: (update with clinical template)

- Weight
- Waist Circumference
- BMI
- Blood Pressure
- Pulse Rate
- QRISK
- HBA1C
- Lipid profile
- Liver function
- Renal function
- Thyroid function

- Prolactin
- ECG (if indicated)
- Personal history
- Family history

Lifestyle Advice:

- Smoking
- Alcohol use
- Drug use
- Activity
- Diet
- Oral health
- Sexual health and contraception
- Attendance of health screening

Mental Health Review:

- Functioning:
 - Employment/meaningful occupation
 - Relationships
 - Self-care
- Experience of symptoms and impact
- Risks:
 - Deliberate self-harm and suicide
 - Unintentional self-harm (self-neglect)
 - Harm to others
 - Harm from others (vulnerability)
- Mental health medication review:
- Considering information from results of physical and mental health review, NICE guidelines and patient choice.

Personalised Care Planning – Consider:

- Brief advice/ information (including physical and mental health promotion)
- Signposting (including physical and mental health promotion resources)
- Referral onwards
- Further review/ investigations
- Change in treatment /care plan

- 3.3.2 The Provider shall record all elements of the health checks using an agreed clinical template. This will be made available via the Data Quality Facilitators. This is to ensure that all activity is consistently coded and recorded. For clarity General Practice staff will be responsible for entering information into their clinical system and MPFT will be responsible for entering information into RiO.
- 3.3.3 The Provider shall deliver the service in line with the pathway outlined in Appendix 1 and the following model:

All people registered on the GP SMI register (regardless of whether open to MPFT or not) are invited to attend a review on an annual basis by the GP practice.
(Preferably have relevant blood tests prior to appointment so that results are available for appointment)

Joint appointment with practice nurse and non-medical prescribing qualified mental health nurse held in primary care; either in GP practice or based on GP locality.

Practice Nurse	NMP
Undertakes physical health assessment	Reviews mental health, functioning and medication alongside the physical health observations and results.
Provide advice, information, signposting, referral, intervention for both physical and mental health needs	
Record in primary care health record	Record in MPFT health record where open to service

Care Pathway

- 4.6 The Mental Health Provider shall initiate treatment onto antipsychotic medication and update the patient's registered GP practice using a standardised letter. This shall include a clear date that the annual check is due. **This will be 12 months after the date the patient was initiated onto antipsychotic medication.**
- 3.2.5 The GP Provider shall invite the patient for an annual physical and mental health check at the practice using their own recall processes and using a standard letter provided for the purpose of physical health checks for patients with an SMI.
- 4.7 The Mental Health Provider shall liaise with the GP Practices within their designated networks, to agree the dates and times a joint clinic will be held. Patients will then be invited into these pre-planned clinics.
- 4.8 The GP Provider shall work with other practices within its network/locality to provide some flexibility for patients to attend nearby clinics, should the registered practices clinic times be unsuitable. The choice will remain with the patient
- 3.2.8 The invitation letter the patient receives will inform them to attend for blood tests prior to the appointment.
- 4.9 The GP Provider shall have a clear process in place for confirming the appointment with the patient if they are being sent a pre-booked appointment.
- 4.10 The GP Provider shall have a clear process in place for following up patients who do not respond or confirm their appointments. This must include a minimum of 3 attempts to contact, with at least one being a written letter. If after 3 attempts the patient is still unreachable, the practice nurse will liaise with the mental health nurse on the day the clinics are run, to undertake a risk analysis and agree next steps together.
- 3.2.11 The GP Provider and Mental Health Provider shall deliver a joint assessment to review the physical and mental health needs of the patient. This will be in line with section 3.2.1 of this

specification. These appointments will be a minimum of 30 mins and maximum of 45minutes and will vary depending on the needs of the patient.

3.2.12 Both the GP Provider clinical system and the Mental Health Provider clinical system shall be updated with the same information within the clinic. General Practice staff will be responsible for entering information into EMIS and MPFT will be responsible for entering information into RiO This is to ensure the patient records are updated in real time and remain consistent. This is until a joint clinical record can be implemented.

4.11 Following the clinic both the GP Provider and the Mental Health Provider shall undertake all relevant follow up actions as identified throughout the assessment.

4.12 The GP Provider shall arrange any follow up appointments required within the practice. This will be with the most appropriate clinician depending on the nature of the request (e.g. medication review with practice pharmacist or cardiovascular review by GP).

4.13 The Mental Health Provider shall arrange any follow up interventions required with mental health services.

4.14 The mental health practitioner will be responsible for updating the MPFT care record and the care team of any person actively receiving care from the mental health provider.

4.15 Both the GP Provider and the Mental Health Provider shall jointly agree any wellbeing interventions required following the assessment. This may include signposting to job centres, voluntary groups to help social isolation issues, or referrals to debt advice services.

4.16 If the patient is receiving their prescriptions from MPFT and not subject to a shared care arrangement with the GP, the prescribing costs shall be attributed to MPFT. If the GP practice is responsible for the mental health medication prescriptions then the costs will remain with the practice and the MPFT clinician will be prescribing as a member of the practice team.

4.17 Population covered

Mental Health Provider:

4.18 The service shall be available for all patients registered with a GP practice in one of the 4 Staffordshire CCGs in South Staffordshire (Stafford and Surrounds, Cannock Chase, South East Staffordshire and Seisdon, East Staffordshire) to whom the commissioner is responsible for.

GP Provider:

4.19 The service shall be available to any patient registered with the practice as a permanent or temporary resident. The practice shall also have the ability to book patients into clinics, which are registered at a GP practice within their Primary Care Network.

4.20 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

- Patients 16 years old and over, who have been on antipsychotic medication for at least 12 months.
- Patients residing in a care home shall be part of the recall system

Exclusion Criteria

- Patients under the age 16
- Patients with a primary diagnosis of dementia shall be excluded as they are subject to separate annual health reviews.
- Patients with a primary need of a learning disability are subject to separate annual health reviews, however it is noted that this model may be extended and aligned once it has had time to embed.

4.21 Interdependence with other services/providers

- Voluntary Sector – support the interventions required as part of the wellbeing follow up
- Acute services
- Dementia pathways and service providers
- Learning Disability pathways and service providers
- Local Authority

4. Applicable Service Standards

4.22 Applicable national standards (eg NICE)

N/A

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

N/A

4.24 Applicable local standards

N/A

5. Applicable quality requirements and Accreditation Requirements

5.3 Applicable Quality Requirements

<https://www.england.nhs.uk/mental-health/resources/smi/>

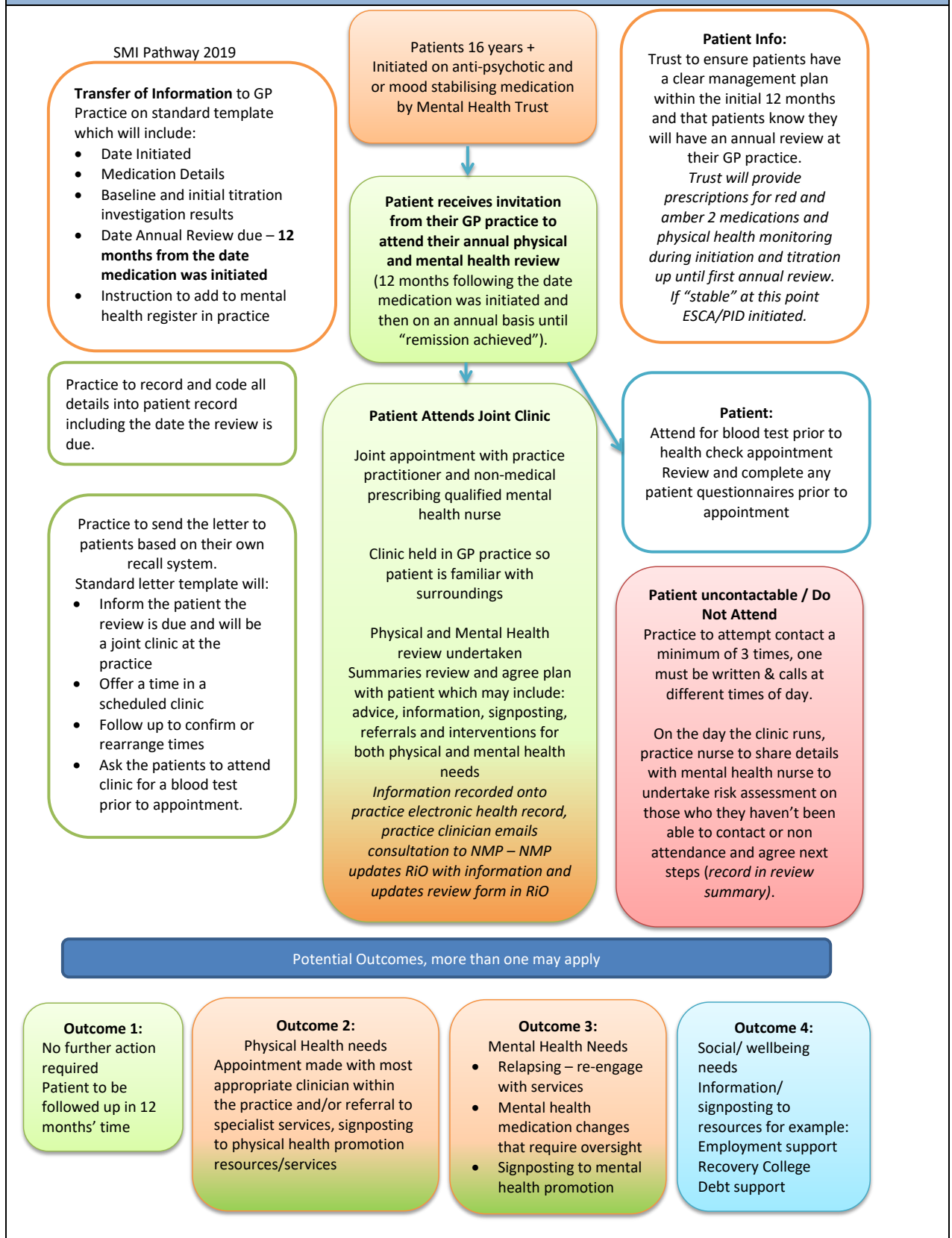
5.4 Applicable Accreditation Requirements

6. Location of Provider Premises

The service will be delivered at various GP Practice locations/clinics.

Clinic location, days of operation and times will be agreed between GP Practices and the Provider.

Appendix 1 – Pathway



Appendix 2 – Pathway Outcome Requirements Table

Physical Health Checks Input – Table 1	1.2.1 Patients on Mental Health Register (Not Coded as In Remission)
	1.4.1. BMI Recorded
	1.4.2. Blood Pressure Recorded
	1.4.3. Cholesterol or QRISK Recorded
	1.4.4. Blood Glucose or HbA1c Recorded
	1.4.5. Alcohol Consumption Recorded
	1.4.6. Smoking Status Recorded
	1.2.2. Patients With ALL 6 Supporting Measures Completed
Physical Health Checks Input – Table 2	1.6.1. Nutritional Status or Diet and Level of Physical Activity Recorded
	1.6.2. Use of Illicit Substance/Non-Prescribed Drugs Recorded
	1.6.3. Medicines Reconciliation or Review Recorded
Follow-Up Interventions input – Table 1	1.8.a. Patients With BMI 25+
	1.8.1. Patients With BMI 25+ offered Weight Management
	1.8.b. Blood Pressure Above Systolic 140mmHg OR Diastolic 90mmHg
	1.8.2. Patients With BP >140/90 Offered Lifestyle Intervention
	1.8.3. Patients With BP >140/90 Offered Pharmacological Intervention
	1.8.c. Patients With HbA1c 42-47mmol/mol OR FPG 5.5-6.9 mmol/L
	1.8.4. Patients With High-Risk/Prediabetic HbA1c or FBG Offered Intervention
	1.8.d. Patients With HbA1c 48+ mmol/mol OR FPG 7+ mmol/L
	1.8.5. Patients With Diabetic Range HbA1c or FBG Offered Diabetic Intervention
	1.8.e. Patients With A Record of Alcohol Misuse or High Alcohol Consumption
	1.8.6. Patients With A Record of Alcohol Misuse Offered Intervention
	1.8.f. Patients Identified As Current Smokers
	1.8.7. Current Smokers Offered Smoking Cessation or Nicotine Replacement Therapy
	1.8.g. Patients With A Record of Substance Misuse
	1.8.8. Patients With A Record of Substance Misuse Offered Intervention
	1.8.9. Patients Offered Lifestyle Interventions
	1.8.10. Patients Prescribed Statins
	1.10.1 Access To National Screening – Eligible For Cervical Cancer Screening

Cancer Screening Input – Table 1	3.4.1. Patients Receiving A Cervical Smear In Last 60m
	1.10.2 Access To National Screening – Eligible For Breast Cancer Screening
	3.4.2. Patients Receiving Breast Screening In Last 36m
	1.10.3 Access To National Screening – Eligible For Bowel Cancer Screening
	3.4.3. Patients Receiving Bowel Cancer Screening In Last 24m

Service name	Specialist Dementia Service - In Reach - HMP Stafford, HMP Oakwood, HMP Dovegate
Service specification number	MH_25 (DIS 02)
Commissioner Lead	Health and Justice Commissioner (NHS England and NHS Improvement) in collaboration with Staffordshire and Stoke-on-Trent ICB
Provider Lead	Midlands Partnership Foundation Trust
Period	1 st April 2023 – 31 st March 2024
Date of review / contract renewal notification by	31 st December 2023
Service description and location(s) from which it will be delivered	
Aims and objectives of service	
The primary objective is to provide prisoners with the same level of dementia related care which would be available to the community population.	
Service description/care pathway	
The Provider is expected to provide the following within the prison: - Screening clinic for over 60's –screening sessions for the over 60's population within the prisons on a regular basis. To include routine mental health assessment, cognitive screen and risk factor identification. Those with baseline symptoms identified at these screening clinics, will receive ongoing monitoring by the service. - Trial the reduction in age for screening to 60+ (from 50+) with a 12 month review in March 2023. - Age 50-59 will be screened by exception, if symptomatic. - Diagnostic Clinics –regular clinics for those within the prison identified through whatever means with cognitive deficits and potential dementia diagnosis. To promote early diagnosis, advice and potential treatment options. - Follow Up/Review clinics –regular clinics for follow ups as required following any further investigations required. Also review of treatment if initiated during titration process and then ongoing monitoring of this treatment effectiveness. - Behaviour Management –assessments on a as required basis for those with a diagnosis of dementia who are displaying challenging and complex behaviours within the prison environment offering both non-pharmacologic and, if felt needed, pharmacological solutions. - Liaison with other professionals – Arranging or attending multi- professional meetings if needed. Where additional referrals are required to other professionals/agencies, these would be identified to Practice Plus Group and made by them as the Coordinating Care Provider. - Training – Identified training needs of all prison staff and provide sessions on dementia and associated issues. - Supervision – Offer of supervision sessions for frontline staff in understanding and managing dementia with the prison environment - Screening of over 50 in HMPYOI Drake Hall and HMP Foston Hall if symptomatic.	
Referrals	
Referrals to the service will only be made by a clinician from within the prison healthcare team Referrals must be reviewed and acknowledged by the Provider to the referrer within 5 working days.	
Assessment	
The Specialist Nurse Practitioner shall undertake a clinical assessment of all individuals referred into the service who require an assessment to ascertain whether or not they have a diagnosis of dementia. The clinical assessment shall include as a minimum Review of medical history	

- Review of GP COG or 6CIT screening
- Review of Blood test results
- Cognitive and mental state examination
- Physical examination as needed and any other appropriate investigations, including referral back to GP (ie, when there are co-existing conditions)
- Review of medication
- Mental Capacity Assessment (depending on decision being made, specific to the time and assessment)
- Assessment of Dysphagia
- Interpretation of diagnostic results
- Referral for another multi-disciplinary opinion

The Provider shall ensure that the diagnosis is communicated to the individual, face to face in an appropriate setting.

Plan and treatment following the diagnostic assessment the Nurse Practitioner shall arrange to meet with the individual to discuss the diagnosis and provide a further range of information and advice for those with non-treatment and treatment requirements. This will include a minimum of the following:

Information and guidance on how people with dementia can improve their general health, live positively and maximise their quality of life after diagnosis;

Services that can support with other health or social care needs

Advice and support on planning for the future, including legal matters associated with loss of capacity, including power of attorney, managing finances and benefits and advance directives. This includes useful documents which can support with describing future wishes.

The Service shall ensure that for those individuals diagnosed with dementia, have a personalized care plan and on-going support.

Personalised Care Plan

The Provider shall ensure that for all individuals diagnosed with dementia, a personalised Care/Treatment plan is developed in consultation with the individual and other relevant professionals, enabling treatment and/or support to commence. This shall include the Emergency Plan for a crisis or challenging behavior.

The Provider shall ensure that there is multi-disciplinary professional input into the Personalised Care Plan and reviews where required.

The Provider shall ensure that the personalised care plan details decisions around timely interventions.

The Provider shall ensure that conversations around End of Life are commenced along with information on Advanced Planning.

The Provider shall ensure that the outcome of the diagnosis whether treatment or non-treatment is reported to the Prison GP in order for the patient records to be updated.

For those patients on a treatment pathway a further follow up appointments will be arranged following initiation of treatment in order to undertake titration.

The Provider shall follow the Treatment pathway under NICE and the Shared Care Protocol

Population covered

HMP Stafford
HMP Oakwood
HMP Dovegate

The services to be provided at:

HMP Stafford
54 Gaol Rd,

Stafford
ST16 3AW

HMP Oakwood

Oaks Drive
Featherstone
WV10 7QD

HMP Dovegate

Moreton Lane
Uttoxeter
ST14 8XR

Screening will take place at HMP YOI Drake Hall and HMP Foston Hall sites, if over 50 and symptomatic.

Any acceptance

Acceptance Criteria

- Any individual at HMP Stafford, HMP Oakwood and HMP Dovegate presenting with symptoms consistent with suspected dementia rather than a physical or functional mental illness will be accepted into the Service.
- Individuals at HMP Stafford, HMP Oakwood and HMP Dovegate who are over 60.
- Individuals over 50 at HMPYOI Drake Hall and HMP Featherstone who are symptomatic.

Clinical Management Responsibilities

Practice Plus Group

- Generating referrals, and maintaining waiting lists and appointments
- Reducing DNA's to the Specialist Dementia Service
- Providing hosting space for the Specialist Dementia Service.
- Record patient access to the service on SYSTM1
- Ensuring that gate staff are aware the Provider is attending the prison (day and time, and what equipment will be carried)
- Undertake any screening tests required i.e.) blood tests
- Identify any health-related risk factors and share with the Specialist Dementia Team, i.e.) hypertension/atrial fibrillation/high cholesterol/obesity/diabetes
- Identify any other risk factors that the Specialist Dementia Team may need to be aware of before delivering a service to patients
- Where possible, 6CIT at reception screening and induction programmes will take place for new patients (meeting the eligible criteria)
- Arrangement of any CT/MRI scans that are required to be completed by external hospital will be made by Practice Plus Group
- Continuation of any pharmacological interventions that are prescribed as a result of the diagnosis made by the Specialist Dementia Team
- Communicate with the Specialist Dementia Team any MDT meetings that they may be required to attend

MPFT (Specialist Dementia Service)

- Where the acceptance criteria has been met, respond to referrals for patients who are prisoners
- Communicate with Practice Plus Group when clinics and appointments will be scheduled
- Communicate with Practice Plus Group any screening/diagnostic test requirements for each patient
- Delivery of the service to patients outlined in this service specification
- Initiate any prescribed treatment and follow-up patients whilst on treatment
- Communicate with Practice Plus Group any other ongoing treatment requirements and recommendations for care
- Engage in MDT meetings held by the prison for patients where Specialist Dementia care is being provided
- Communicate with Practice Plus Group when patients have been discharged from the Specialist Dementia Team

Other specific requirements relating to HMP

- The service is delivered in the secure environment and must comply with the prisons arrangement for security and safety. There are a number of items that are prohibited from being taken into the prison environment. These include mobile phones, cash larger than £50, illicit drugs and prescribed medicines, recording devices, IT equipment and smoking paraphernalia. Lists of prohibited items are available in all prison reception areas, and it is advised that staff review these before entering.
- The Provider is expected to work with the prison security teams to ensure any equipment is checked in and out of the prison. Advice can be sought from the prison healthcare team where there is any uncertainty
- The Provider should expect for staff to be searched upon entry to the prison
- The Provider will be escorted to and from the clinic location by either prison or healthcare staff or keys will be provided where key training has been undertaken and the prison has agreed for the staff member to carry keys.

Reporting and Outcome Measures

Reporting

- Number and percentage of referrals that are reviewed and acknowledged by the Provider to the referrer within 5 working days
- Number of screenings carried out, per prison site
- Number of residents receiving a diagnosis of dementia
- Average and longest wait time from referral to screening appointment

Outcome Measures

Quantitative

- Number and percentage of referrals that are reviewed and acknowledged by the Provider to the referrer within 5 working days
- Number of screenings carried out, per prison site
- Number of residents receiving a diagnosis of dementia
- Average and longest wait time from referral to screening appointment

Qualitative

- Percentage of patients demonstrating a Dementia Quality of Life (QOL) score improvement (who have completed treatment or 6 months in to treatment)

Service Specification No.	MH_26
Service	Participation Grant – Mental Health (MH), Children and Young People (CYP)
Commissioner Lead	Simon Runnett
Provider Lead	Natasha Khan
Period	April 2023 – March 2024
Date of Review	March 2024

Population and/or geography to be served	National Context & NHS Long Term Plan The NHS Long Term Plan (LTP) sets out the priorities for expanding Children and Young People's (CYP) Mental Health Services over the next 10 years. The aim is to commission services closer to home, reduce unnecessary delays and deliver specialist mental health care which is based on a clearer understanding of young people's needs and provided in ways that work better for them. The NHS Constitution enshrines public ownership of the NHS as a fundamental value. Building on the constitution, the Five Year Forward View sets out a vision for growing public involvement. This will be achieved by developing effective, evidence based services that combine local, system wide leadership and ownership with the participation of essential partners including children, families and carers. Participation and the Wider Community Integration and participation of young people and families safely and meaningfully in every part of what we do, working in partnership with CYP, parents and carers and services, will serve to increase the capacity of the system to support CYP participation for full co-production. The team will deliver to the following areas: South-East and South-West place. Acceptance Criteria: • CYP aged up to 18 years and 364 days that have accessed mental health service either in the past or who are currently accessing services • CYP registered with a GP in the above areas. • CYP with EHCP in place up to their 25th birthday • Responsible Commissioner guidelines shall be adhered to particularly in respect of looked after children placed within the geographical region of South Staffordshire even if the child / young person is registered with a GP in South Staffordshire

Service aims and desired outcomes	Service Description: - The team will have a key role in helping current / past mental health service users to get involved and play an active role in the developing and shaping of mental health services. Aims - Active involvement of others in service delivery and the development of services need to be sustained and to grow in order to shape current and future service around what matters to them. Putting the experiences of children, young people, parents and carers at the centre of service design to help to shape future and improve our services. Participation and the Wider Community - Integration and participation of young people and families safely and meaningfully in every part of what we do, working in partnership with CYP, parents and carers and services, will serve to increase the capacity of the system to support CYP participation for full co-production Thrive - THRIVE offers a set of principles and values to guide service implementation. It takes a whole system approach and focuses on building individual and community strengths; ensuring that children, young people and families are active decision makers in the process of choosing the right service approach. It also draws a clearer distinction between treatment and support. - This team will support embedding the THRIVE principles of prevention and early intervention,, building resilience and confidence using a place based approach; participation and a Digital offer providing Information, Advice and Guidance for support and early intervention delivered via website information offering online coping strategies, apps and signposting to other service to enable self-management and build up resilience. NHS Outcomes Framework Domains & Indicators Since 2013, NHS England has been working to improve the outcomes and experiences of people of all ages with mental health problems, to ensure that mental health is treated on a par with physical health. - To achieve this, we are working closely with service users, carers, other national NHS bodies and key partners such as social care and the voluntary sector. - To champion a culture of participation across the local system – making it ‘child-centred.’

Aims and outcomes:

Child young person

- Recruit CYP to the programme
- Children and young people are involved in all aspects of the development and improvement of the team such as peer evaluator schemes or by participating in improvement projects
- Children and young people are involved in the design, leadership and delivery of priority initiatives
- Designing leaflets, websites or other communications and resources aimed at children, young people are developed in partnership with them
- Children and young people to be involved in the recruitment and induction of anyone who has contact with them, as well as managers and leaders
- Children and young people are involved in the design of, or improvements to, the service's settings and the physical environment
- The team works collaboratively with local and regional partners to promote children and young people's participation e.g. commissioners
- Senior leaders in the organisations and system routinely hear CYP feedback

Parents and Carers

The team will work collaboratively with parent services and groups across the local community to include parents of CYP who are currently or were previously accessing MH services.

- Enable them to become part of our community, helping to hear parents' voices when it comes to mental health service design
- Senior leaders in the organisations and system routinely hear Parent and Carer feedback
- Parents and carers are offered opportunities to support them to participate actively and meaningfully
- Parents and carers are involved in participation represent the local population, including socially marginalised groups

The Provider of the Service will:

- Invite any CYP and Parent/Carer who wishes to be involved in team activities
- Provide a Lead Participation member of staff for CYP and Parents and carers to link with
- Gain insight/views from hard to reach groups such as CYP of teenage parents.
- Be innovative with technology and utilise website and other mediums to publicise more opportunities for local and national involvement to young people and parents/carers

	• Advocate the importance of hearing the voices of children, young people and parents/carers throughout the mental health system. • Involve service users in recruitment i.e. MHST • Build the knowledge, confidence and skills of professionals across the mental health system around participation • Help CYP to influence senior managers, persuasion and leadership from within the system – lobbying, winning hearts, generating ambition and commitment • To see the value and understand the potential impact of participation to address the challenges to making it happen. • Embed participation within your strategic approach to transformation • Have effective feedback loops between the organisation / partnership and children and young people who participate
Service description and location(s) from which it will be delivered	Integration of participation of CYP and families safely and meaningfully in every part of what we do, working in partnership with CYP, parents and carers and services, will serve to increase the capacity of the system to support CYP full co-production. This will build knowledge, confidence and skills of professionals across the mental health system around participation. Increasing participation of CYP and their families in the CYP's mental health system – at individual, organisational, local and national levels, embedding participation in all services will support this approach. CYP, parents and carers understand that their involvement in service level and local decision-making around mental health services could improve services and local systems Location of provider premises The Provider shall provide a location from which the team can be based. The Provider will be able access other community venues / premises, but also deliver services in various locations across South/East/West Staffordshire that is accessible to local communities. The Provider premises and reception facilities shall be child / young person friendly and easily accessible from main transport links. Services will comply with You're Welcome Standards Accessibility • The team shall feed into mental health service's within the geographical area of South Staffordshire • Ensure that the team are accessible • The provider will address health inequalities, by promoting inclusion from vulnerable, disadvantaged and disproportionately affect young people from Black and Minority Ethnic (BAME) groups. • Vulnerable groups will be targeted with the aim of equity of outcome through the flexible delivery of participation activities.

	Ensure activities are available to all without regard to disability, gender, sexuality, religion, ethnicity, social, or cultural determinants. Applicable national standards Transition from children from children's to adults' services for young people using health or social care services social care services NICE guideline Published: 24 February 2016 nice.org.uk/guidance/ng43 Self-harm in over 8s: short-term management and pre management and prevention of reoccurrence Depression in children and young people: Quality standard [QS48] Published date: September 2013 Antisocial behaviour and conduct disorders in children and young people Quality Standard Published: 17 April 2014 Clinical guideline Published: 28 July 2004 nice.org.uk/guidance/cg16 Antisocial personality disorder: Antisocial personality disorder: prevention and management Published: 28 January 2009 nice.org.uk/guidance/cg77 Borderline personality disorder: Borderline personality disorder: recognition and management recognition and management Clinical guideline [CG77] Published: 28 January 2009 last updated March 2013 nice.org.uk/guidance/cg78 Coexisting severe mental illness and substance misuse: community health and social care services NICE guideline Published: 30 November 2016 nice.org.uk/guidance/ng58 Learning disability: identifying and managing mental health problems managing mental health problems. Quality Standard Published: 10 January 2017 www.nice.org.uk/guidance/qs142 RCPCH: Involving children and young people in health services children: Nov 2013 Depression in children and young people: identification and management (NG134) NICE guideline Published June 2019 Depression in children and young people (QS48) Quality standard Published September 2013 Interdependence with other services / providers The Provider shall foster interdependencies and relationships with other essential service providers. But not be limited to: • CAMHS • Educational Psychologists

	• General Practitioners • Secondary Care Providers • Social care providers and commissioners • Safeguarding professionals • Education providers • MHST Teams • Community health providers • Acute Providers • Housing • Youth Offending Services/Forensic Services • Learning Disability Services • Voluntary / Third Sector

Service Specification No.	MH_30
Service	<i>Children and Young People (CYP) Complex SEND Care Co-ordination (Autism Service)</i>

Population and/or geography to be served	The service shall be available to children and young people (CYP) with an EHCP (where a requirement for Care Co-ordination is specified) up until the day of their 25 th birthday who are registered with a General Practitioner within the geographical boundaries of South West and South East Staffordshire. For any child or young person who has moved from another area, then Staffordshire ICB will become the responsible commissioner.															
Service aims and desired outcomes	<u>NHS Outcomes Framework Domains & Indicators</u><table><tr><td>Domain 1</td><td>Preventing people from dying prematurely</td><td></td></tr><tr><td>Domain 2</td><td>Enhancing quality of life for people with long-term conditions</td><td></td></tr><tr><td>Domain 3</td><td>Helping people to recover from episodes of ill-health or following injury</td><td></td></tr><tr><td>Domain 4</td><td>Ensuring people have a positive experience of care</td><td>X</td></tr><tr><td>Domain 5</td><td>Treating and caring for people in safe environment and protecting them from avoidable harm</td><td></td></tr></table> Aims and objectives of service • To meet the requirement of an EHCP where care co-ordination is specified. • To partner with patients/carers and professionals to ensure the needs of the CYP are met in a pro-active and joined up way. • To support the co-ordination of complex health needs for CYP in line with their EHCP. • To work with professionals to ensure that health needs are adequately represented within EHCP's. • To contribute to annual reviews of EHCP's. • To co-ordinate and facilitate multidisciplinary/multiagency meetings as required. To support joined up proactive care. • To participate and give advice, within the remit of their professional expertise, to relevant MDT/MDM's where health is not the lead agency (eg CIN).	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	X	Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	
Domain 1	Preventing people from dying prematurely															
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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															

	• Ensuring compliance with statutory requirements through engagement and working in conjunction with the Designated Clinical Officer (DCO) for Special Educational Needs and Disabilities (SEND). • To advocate for the family and CYP. • CYP/Parents feel supported and empowered (however, it will remain the responsibility of the parent to manage appointments etc). • To develop positive relationships with other agencies. • To recognise changes and escalation in need and to take appropriate steps/action (eg safeguarding/crisis etc). Local defined outcomes • Support to CYP and family to navigate NHS pathways and prevent deterioration. • A joined up approach between services to result in seamless communication/facilitation between health, education and social services. • Reasonable adjustments are made for CYP and their families. • Health contributions to an EHCP is up to date and accurate. • Improved mental health and well-being of the CYP and family. • CYP and Families have a positive experience of care provided. • Effective transition to adult services is supported.
Service description and location(s) from which it will be delivered	Service Description The Care Co-ordinator will be a qualified health professional with experience of autism and attachment-based difficulties and learning difficulties. The Care Co-ordinator role is expected to include: • Attendance at relevant Multi-Disciplinary Team (MDT) meetings in all settings to support and coordinate the delivery of the services stated in the EHCP. • The MDT will provide an opportunity to meet with any relevant professionals. • Ensure the voice of the CYP remains central to decision making. • Contribution to EHCP assessments/annual reviews for the CYP known to the service, this will include providing reports/information regarding identified health needs and provision required in line with the statutory timeframes. • Review of EHCP draft plans for which they have provided information to quality assure the accuracy of the information included in line with the specified timeframes. In summary, the Care Co-ordinator role will include:

- The Care Co-ordinator will assure that the objectives and goals agreed with the CYP and stipulated in the EHCP are achieved through the effective delivery of care by the appropriate agency or provider.
- Involvement in relevant multi-agency meetings and education reviews.
- Liaison with the CYP, their family and involved agencies and professionals.

Operational Hours

The service will be available during the Care Co-ordinator's working hours only and will not operate as a 24/7 service.

Population covered

The service will be available to who is registered with a GP practice within the geographical boundaries of South West and South East Staffordshire.

Any acceptance and exclusion criteria and thresholds

The service will be available to any identified CYP currently in receipt of an Educational Health and Care Plan (EHCP) where Care Co-ordination support is stipulated, and with a diagnosis of Autism.

The service shall be available to children and young people (CYP) with an EHCP (where a requirement for Care Co-ordination is specified) up until the day of their 25th birthday who are registered with a General Practitioner within the geographical boundaries of South West and South East Staffordshire. For any child or young person who has moved from another area, then Staffordshire ICB will become the responsible commissioner.

Interdependence with other services/providers

The Care Co-ordinator will work in partnership with various agencies including Healthcare, Social Care and Education and any other service which is involved in the CYP's care requirements.

It is important to ensure that all agencies are in support of the Care Co-ordinator role and remit, therefore it may be necessary to convene a meeting with relevant partner representatives to discuss any potential issues and expectations in this regard.

Service Specification	ASSOC-01 Adult Ability Team Service Specialist Community Care for People with Progressive Neurological Conditions
Commissioner Lead	Howard Ford, Senior Commissioning Manager Derby
Provider Lead	Steve Foster
Period	1 st April 2020 – 31 st March 2021
Date of Review	By 30 September 2020
3. Scope	
3.1 Aims and objectives of service	
Aims - To provide a high quality, safe, accessible service to people over the age of 18 years affected by a progressive neurological condition, promoting health, well-being and maximum independence, reducing the development of short and long term complications through specialist interventions. - To deliver specialist care in the most appropriate setting, ensuring that the person is seen by the right health care professional. - To work collaboratively with other providers, as appropriate, to enable smooth and timely transition between services. - To promote a person-centred approach, placing the service user at the heart of decisions about their treatment; respecting their autonomy, choice and values. - To encourage patients to take ownership of their condition and self-manage wherever possible. - To develop and improve the service by engaging with and listening to service users using innovative and flexible approaches. - To provide an efficient and effective service that makes best use of resources. Objectives - To deliver a community based specialist service in line with national guidelines, which supports people with progressive neurological conditions to manage their condition by offering high quality, evidence informed nursing and therapeutic assessment and intervention, education, information and advice. - To reduce unplanned hospital admissions related to people's progressive neurological conditions. - To support people with a progressive neurological condition to self-manage as far as possible and appropriate. - To support service users and their carers towards an improved quality of life. - To reduce the number of G.P and Hospital appointments. - To audit and evaluate clinical practice and service delivery, to ensure appropriate use of resources and identify areas for potential improvements.	
3.2 Service description/care pathway	
Progressive Neurological Conditions fall into 3 main categories: Progressive conditions where treatment is often over many years and management becomes insidiously more complex e.g, Muscular Dystrophy and Multiple Sclerosis. Conditions which progress and despite intensive treatment inevitably worsen and management becomes more complex e.g, Parkinson's. Irreversible conditions giving rise to severe disability and inevitably lead to death such as Motor Neurone Disease	

Specialist Neurological Occupational and Physiotherapists, Parkinson's and Multiple Sclerosis Nurses and support staff offer personalised rehabilitation, symptom management and medication support. Packages of intervention aim to maximise functional ability, physical and psychological wellbeing and promote a holistic approach to self-management. Interventions are primarily provided within a person's own home but some may be delivered in a group setting in another location. Groups may include falls management/physiotherapy, fatigue management education programs and courses for newly diagnosed patients.

3.3 Population covered

The Adult Ability Team provides a community based service to those over 18 years and who are within the East Staffs CCG population ie: those who are registered with an East Staffordshire GP and have a diagnosed progressive neurological condition.

Referral Route

Sources of Referral:

- GPs
- Hospital Consultants
- Other health professionals
- Social care
- Voluntary organisations
- Service users have who received a service from the Adult Ability Team in the past 12 months can re-access the service themselves via the Care Co-ordination Centre.

Discharge Criteria

- Patients are discharged from the service when any of the following are the case:
- Service user and clinician agreed goals are met
- The service user is assessed to be competent to self-manage their presenting/assessed needs
- Care is transferred to another service
- The service user has demonstrated poor attendance or compliance with interventions
- No contact from the service user for over 6 months for low and medium risk patients.
- High risk service users are offered a follow up appointment before discharge if there has been no contact for 6 months

3.4 Any acceptance and exclusion criteria

Acceptance Criteria

- Consenting individuals over the age of 18 years with a medically confirmed diagnosis of a progressive neurological condition, registered with an East Staffordshire GP.
- Adult Ability will only see the people if Adult Ability are best placed clinically to see those people. The team will triage to the most appropriate service based on the presenting need (ie if the reason for the referral is a bad back but they have Parkinson's then they will be triaged to MSK).
- Following triage Adult Ability would process an internal referral to whoever is best placed to meet the need – and where necessary work jointly between teams.

Exclusion Criteria

- People under the age of 18 years
- People without a confirmed diagnosis of a progressive neurological condition
- People whose primary presenting need is not as a direct result of their progressive neurological condition e.g Orthopaedic conditions
- People residing outside of the East Staffordshire population
- People whose primary presenting nursing need is palliative/end of life care. These people will be seen by the palliative care team.
- Routine annual review of patients with a progressive neurological condition where they are being reviewed elsewhere (e.g University Hospitals of Derby and Burton NHS Foundation Trust) unless there is a presenting need which can only be met by the expertise of the Adult Ability Team.
- Where the presenting need is a musculoskeletal condition and the person is able to attend a clinic appointment.
- Equipment only referrals into Occupational Therapy where the referring service is able to safely and appropriately meet the need or where the service user is safely
- Assessment due to the breakdown of care, either agency or informal.
- A moving and handling assessment to inform care provision within 72 hours of hospital discharge and/or where there is no progressive neurological need.
- Service users whose primary presenting need is mental health or behavioural in nature.

Total workload for all Derby adult ability patients :

Figures are from June to November 2019: FOT April to March

	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	PYE	FOT
Exercise class/group number of attendees (total for period)	6	7	1	0	2	1	17	34
Home Visits								
Number of patients	23	30	20	13	12	16	114	228
Home Visits	20	37	21	8	7	17	110	220
Telephone calls	19	15	18	20	9	9	90	180

Derby & Derbyshire CCGs

Total value of the contract is £75,000 (inclusive of CQUINs)

Value to be invoiced monthly £6,250

Service Specification No.	FRS_01
Service	Falls Responder Service
Commissioner Lead	Sharon Cooper
Provider Lead	
Period	1 st April 2022 to 31 st March 2023
Date of Review	Upon Commissioner or Provider request

1. Population Needs

1.1 National/local context and evidence base

A study of the London Ambulance Service in 2003/04 showed 8% of 999 calls were from older people who had fallen and 60% of these were conveyed to hospital. The study showed that 47% of people called 999 again at least once and there was an increased risk of death and of hospital admission compared with the general population of the same age living in London. (Snooks HA)

In 2012, it was estimated that 800 people fall every day in the West Midlands and fall detectors were recognised as an under used resource. Whilst a fall detector does not prevent a fall, it will send an alert so that someone knows that a person has fallen and we know from research that this can make a big difference to people's lives by restoring confidence in living independently safe in the knowledge that if a fall occurs someone will come. (Coventry HDTI)

Last year, over a 3 month period (Nov 2011 to Jan 2012) our local A&E Department reported 342 falls related presentations from North Staffordshire residents. Of these, 153 (44%) were from people over the age of 65 who were not admitted. We know however that data on falls is inaccurate beyond the 999 call, so the numbers are likely to be much larger.

A traditional ambulance service like WMAS provides services which are organised around the needs of service user with life threatening emergencies providing :

- Automatic dispatch of lights and sirens ambulance to all calls
- Paramedic staff, service user carrying vehicles are the only option
- Response time targets for all calls
- Most service users conveyed to hospital unless they refuse to travel

For the financial year 2011/12, WMAS received 4,259 falls related 999 calls from North Staffordshire residents not living in a nursing or residential home. Of this 1,857 were from people who had fallen in their own home and called 999 more than once. We could therefore assume that these were the people at risk of further falls although there would still be a further percentage of people (from the 4,259 calls) who had fallen but who would not benefit from this proposed new service.

The following issues have been identified locally:

- WMAS report that falls consistently amount to approximately 17% of calls each day and this often increases during winter weather. It doesn't dip much lower than this.
- WMAS report that last year they conveyed 56% of fallers to A&E although a large proportion were later discharged with no further treatment.
- Paramedics report that many people who have fallen just wish to be helped up again and they can become agitated when the paramedics have to convey to A&E or take vital signs before leaving.
- Many 999 calls are received from people who have a history of falls and are known to paramedics, however many of these people do not have a package of care to manage the risk of further falls.
- West Midlands Ambulance Service (WMAS) state that their activity for falls peaks during the morning (7am -10am) and this is often due to people falling during the night and not being able to get up again. They are usually found by family or friends the following morning. These incidents often lead to other pathologies requiring a longer stay in hospital. Incidents like this also increase the likelihood of anxiety, depression, leading to social isolation brought about from the fear of falling again.
- Many people who call 999 following a fall are conveyed to A&E where they are later discharged home again with no further treatment. Paramedics have to make a judgement regarding the person's safety and if they are unable to contact a GP within a very short timeframe, they default to conveyance to A&E.
- The Staffordshire Fire and Rescue Service report a link between elderly people who fall and the danger of house fires. This is due to elderly people sitting near to a fire and when they stand and fall, they often fall on the fire. This risk impacts directly on the fire and rescue service who also provide a free home fire safety assessment service which is under-utilised.
- Case Study examples :-
 - o Elsie was an elderly lady who fell in her own home. She was initially uninjured but she was unable to get up again and she had fallen next to a hot radiator. She was unable to crawl away and was unable to call for help via a telephone. When help did arrive she had been on the floor for a couple of hours. She had to be hospitalised for severe burns to her scalp. Her resulting injuries from being on the floor for so long were completely avoidable.
 - o Olga was an elderly lady, living alone in her own home. She had no fire safety equipment and had an open fire. One day she fell but because she was sitting so close to the fire she fell onto it. The fire burned through the whole of her house and officers reported her body to be "unrecognisable". This was completely avoidable.
 - o Jane cares for her husband at home. Her husband has survived 2 strokes and he also has dementia. He is unable to get up unaided after a fall and he is unable to use a mobile phone. Janice feels isolated as she cannot leave her husband for fear of him falling and being left unattended.

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

See Schedule 4 Part C Local Quality Requirements

3. Scope

3.1 Aims and objectives of service

- To provide care closer to home
- Reduce the number of unplanned hospital admissions
- Reduce the number of 999 calls
- Provide fast timely assessment and treatment
- Provide reassurance to promote independence and reduce anxiety
- Support early discharge of service users at risk of falls from acute settings through provision of a safer home environment
- Reduction in service user exposure to health care associated infection
- Reduction of inappropriate admissions
- Reduction in 999 calls to WMAS
- Improved service user experience
- Reduced service user anxiety
- Increased independence and quality of life
- Improved communications within and across health and social care boundaries
- Reduced risk of acquiring secondary care infections

3.2 Service description/care pathway

The service shall be accessible 24 hours per day, 7 days per week and 52 weeks per year.

Service users referred to the service will receive training and equipment within 2 days of receipt of referral

The service is a needs based falls responder service with clinical triage for people who are:

- At risk of repeat falls and related injuries
- Living in their own home or residential care (not a nursing home)
- Registered with a GP in North Staffordshire or living within the boundaries of North Staffordshire.

The Falls Responder service Shall provide :-

- Clinical Triage in the community to determine appropriate level of assistance required
- Communication to WMAS for conveyance to A&E only when necessary
- Social Care Responder Service including first aid, treating the service user in their home
- Links to a free home fire hazard assessment provided by Staffordshire Fire and Rescue Service
- Opportunity to obtain equipment to make their home environment safer

The service shall provide reassurance and if appropriate shall safely help the service user from the floor and provide any necessary first aid following activation of the alarm because of a fall. If the service user requires conveyance to A&E an ambulance shall be called immediately. otherwise the responder will telephone the falls responder nurse to discuss the decision to keep the service user at home and the final decision not to convey will be made during that call. Responsibility for the decision is with the falls responder nurse. The service shall: -

- Help the service user up after a fall, using the latest lifting cushions
- Provide first aid to deal with a wide range of injuries.
- Provide clinical triage to ensure the service user is safe to stay at home
- Provide a welfare visit to see how the service user is after a fall or at any time if they feel unwell on request.
- Check the Service user is not injured beyond needing first aid and ensure the service user is reassured and no longer anxious about their experience.
- If they activate the community alarm but the Control Centre cannot get in touch. The responder must make a visit within 20 minutes of the alarm being activated.
- Inform the service users' GP of all referrals to the service and of the outcome of any alerts to the service.
- Following a fall, the responder shall stay with the service user until they are no longer anxious.
- Where a service user has not alerted the service of a fall within a 6 month period, the service will visit the service user to assess continued need for the service provision. The outcome will be discussed with the service users GP and an exit strategy will be agreed with the GP and service user for those who no longer require the service.
- Service users who engage with the Fire Service shall be advised about fire hazards and offered a free home safety assessment. The service offer equipment free of charge to reduce the risk of fire in the home, which increases with people who are at risk of a fall.

- Service users who engage with the Falls Response service shall be issued with appropriate assistive technology including falls detector and a key safe. They shall receive advice and guidance regarding using both. The key safe shall enable the Falls Responders to access their home when they are unable to answer the door. The service user shall be advised what to do when they fall and what to expect from the new service when they trigger their falls alert pendent.
- The clinical element of the falls responder service shall provide assessment to reduce the risk of service users being kept at home when they need to be in a hospital environment.

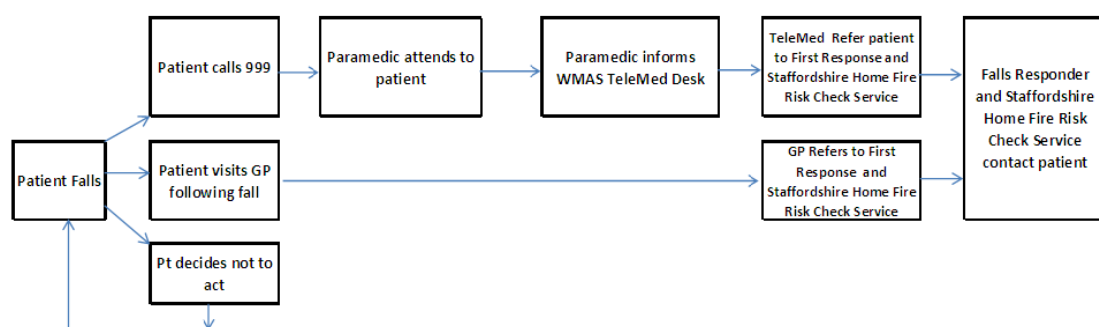
Any alert from the service user shall be picked up by the responder service. This team shall alert the community clinical triage element and shall provide details of the situation. The clinician shall also attend to the service user within a 45 minute timeframe. This clinical triage element shall ensure the service user is treated in an appropriate and safe location and not kept at home when they need to be in hospital.

The service shall refer service users to other services in the Falls pathway such as exercise and rehabilitation and will inform the service user's GP when this is done.

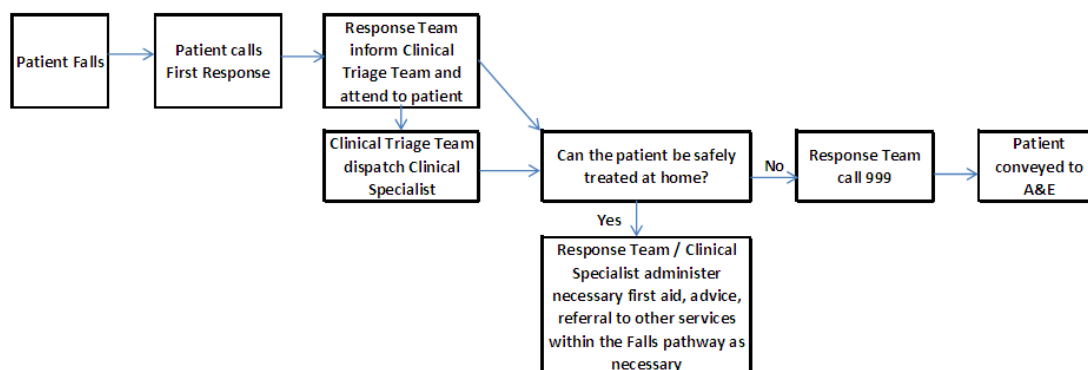
Referral Pathway

GPs, A&E consultants and WMAS staff can refer to the new Falls Responder Service.

Many service users will be identified following the initial 999 call for a falls related incident. WMAS paramedics who attend shall advise the potential service user about the Falls Response Service and Staffordshire Fire and Rescue Home Fire Risk Check Service. They shall obtain consent from the potential service user prior to referring them through their Telemed Desk. The Telemed Desk shall refer to the Home Fire Risk Assessment and Falls Responder services. The Telemed desk shall also inform the service user's GP of the fall and subsequent referral.



Falls Response Pathway



3.3 Population covered

The service will provide care to all service users registered with a GP in North Staffordshire or living within the North Staffordshire CCG boundaries.

3.4 Any acceptance and exclusion criteria and thresholds

- Adults aged 18 or over shall be accepted
- Service users have fallen or are at risk of falling and whose condition renders them to be at risk of further falls / falls related injuries

3.5 Interdependence with other services/providers

The Service will be expected to integrate and work with numerous partners including:

- West Midlands Ambulance Service
- Staffordshire Fire and Rescue Service
- Other Services within the Falls Pathway
- A&E
- General Practitioners
- Service Users
- Carers
- CCG Commissioners/Service re-designers

4. Applicable Service Standards

Not used

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals – not applicable

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be delivered in the service user's usual place of residence.

7. Individual Service User Placement

Service Specification No.	1
Service	Falls Responder Service
Commissioner Lead	Sharon Cooper
Provider Lead	
Period	1 st April 2022 to 31 st March 2023
Date of Review	Upon Commissioner or Provider request

1. Population Needs

1.1 National/local context and evidence base

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2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

See Schedule 4 Part C Local Quality Requirements

3. Scope

3.1 Aims and objectives of service

- To provide care closer to home
- Reduce the number of unplanned hospital admissions
- Reduce the number of 999 calls
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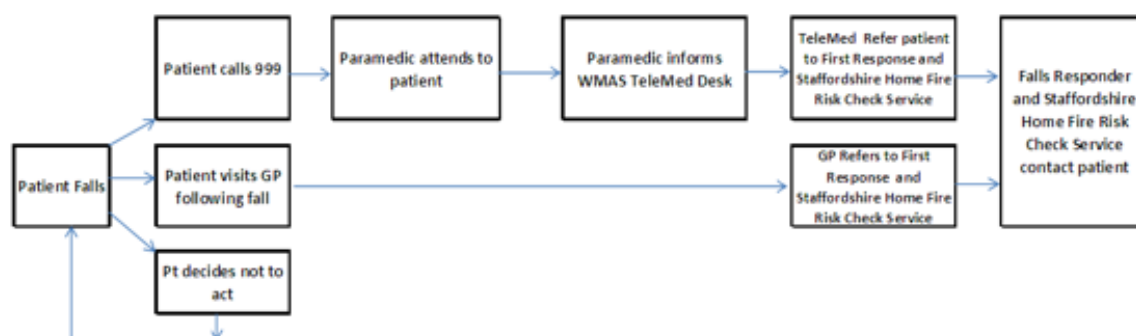
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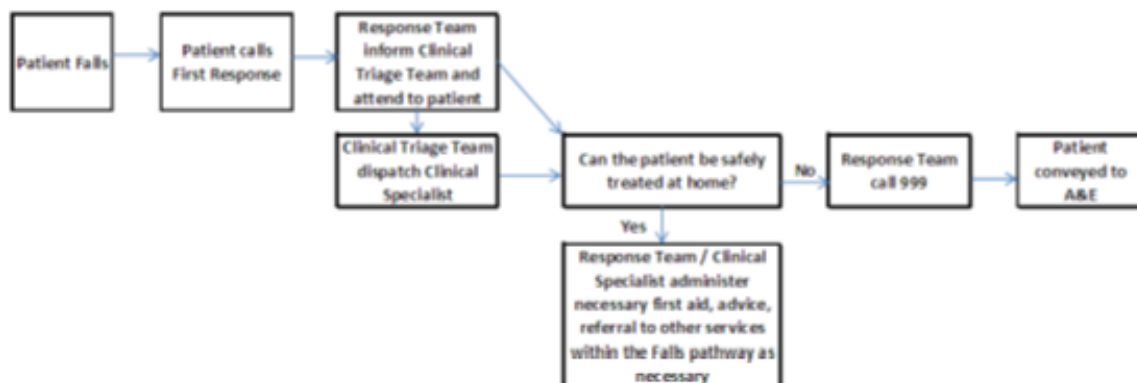
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Falls Response Pathway



3.3 Population covered

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3.4 Any acceptance and exclusion criteria and thresholds

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The Service will be expected to integrate and work with numerous partners including:

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- Staffordshire Fire and Rescue Service
- Other Services within the Falls Pathway
- A&E
- General Practitioners
- Service Users
- Carers
- CCG Commissioners/Service re-designers

4. Applicable Service Standards

Not used

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals – not applicable

Service Specification No.	MICATS_01
Service	MICATS - Community MSK Service
Commissioner Lead	
Provider Lead	Karen Dawson, Service Manager, MICATS
Period	1 st April 2022 to 31 st March 2023
Date of Review	Upon Commissioner or Provider request

1.Population Needs

1.1 National/Local Context and Evidence Base

1.1.1 There are over 200 musculoskeletal conditions affecting millions of people, including all forms of arthritis, back pain and osteoporosis. The World Health Organisation (WHO) AND Bone and Joint Health strategies Project (2005 cited by DOH) identified that:

- Automatic dispatch of lights and sirens ambulance to all call
- Up to 30% of all GP consultations are about musculoskeletal complaints
- Musculoskeletal problems are cited by 60% of people on long term sickness
- 40% of the over 70's have Osteoarthritis (OA) of the knee
- An estimated 8-10 million of the UK population have arthritis, including 1 million adults under the age of 45, upwards of 12,000 children and 70% of 70 year olds
- 80% of people report low back pain at some point in their life
- It is estimated that trauma caused by road traffic accidents (RTA's) will be the third highest ranked cause of disability by 2020⁹

1.1.2 The NHS Five Year Forward View aims to deliver better health, better patient care and greater efficiency within the NHS. To help support delivery of this vision, Sustainable Transformation Plans (STP) are being written across the health systems to show how providers and commissioners will evolve and become sustainable over the coming years.

1.1.3 In 2014 Cannock and Stafford CCG commissioned an Integrated Musculoskeletal Clinical assessment & Treatment Service which became the GPs first point of contact to triage all patients presenting with a Musculoskeletal condition. South East Staffordshire & Seisdon CCG also went through a programme of redesign in 2015 to adopt a similar model of care which aligned with the DOH MSK Framework (2006).

- 1.1.4 Both services now manage over 70% of the patients referred to them and this service specification aims to pull together the two services to provide a clear pathway of care with greater efficiencies to align with the local STP plans for orthopedics.

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

See Schedule 4 Part C Local Quality Requirements

3. Scope

3.1 Aims and objectives of service

- 3.1.1 The provider shall provide a multi-disciplinary, single point of access; community based service which aims to provide timely assessment, diagnosis and treatment of MSK conditions and promotes self-management in order to maximize independence.

The overall aims and objectives of the service are:

- Provide a range of supportive care, advice and treatment for patients with musculoskeletal conditions;
- Facilitate improved health outcomes by reducing the need for surgical intervention where clinically appropriate, and to optimise self-care and self-management;
- Ensure improved patient reported outcomes by using evidence based outcome tools
- Support patients to gain improved physical, emotional and social well-being through reduction in pain/stiffness during periods of exacerbation/injury'
- To implement choice at the point of (onward) referral
- To include the specialist triage of musculoskeletal referrals to ensure patients are seen in the right place by the right person at the right time and actively manages inappropriate referrals through education and support.

- Reduce Service User's with back pain dependency on injection therapy by providing best practice long term management strategies and education to empower the Service User to undertake, and participate in, routine day to day activities.
- To prevent avoidable chronicity for acute Service Users and facilitate optimal quality of life in Service Users with long term un-resolving back pain.
- To use the information contained in the STarT Back Tool as a means to implement stratified care for Service Users with back pain

3.1.2 The Provider shall contribute towards the following outcomes:

- Reduced number of days lost to employment/loss of functional activity;
- Reduced social isolation;
- Reduced time spent off work;
- Reduction in time spent in acute settings;
- Improved musculoskeletal health;
- Reduction in secondary care orthopaedic referrals;

3.2 Service description

3.2.1 The core services shall include:

- Triage, assessment, diagnosis and treatment for Orthopaedic conditions – provided by a multidisciplinary team which includes consultant input appropriate to the condition
- Direct access to diagnostics (ensuring that they are requested appropriately – Royal College of Radiologists 2003) and undertaken prior to first appointment where clinically appropriate.
- Outpatient Procedures in line with the CCG's policy for Excluded and Restricted Procedures (ERP).
- Option to extend interventions as and when innovation and clinical developments are made, this would be agreed by all parties. Pain management services, including appropriate access to psychological support. Delivered directly within the MSK service, or has a seamless pathway into a separately managed service with the same Provider.
- MSK Podiatry (excluding surgery and community podiatry). Already present in MICATS Service and further development to include in IPOPS further development
- Physiotherapy
- Orthotics – Bio mechanical assessment and low level advice & off the shelf products
- Chronic Back Pain Management classes.
- Self-Management and education interventions that follow best practice and national guidelines.

3.2.2 The Provider shall adopt and develop innovative ways of working and consider the following:

- Telephone assessment
- One stop clinics
- Alternative ways to face to face FU
- Support from the voluntary sector

3.2.3 The Provider shall ensure that each patient is provided with the following condition-specific information:

- Description of their condition and its implications;
- Self-Management training and support which empowers the patient to manage their condition and remain as independent as possible in their own home, for as long as possible, this includes the use of digital technology.
- Sources of Support;

- 3.2.5 For patients with back pain symptoms, the Provider shall use the STarT Back screening tool to establish a service Users risk status and the level of input that may be required. GPs will be encouraged to complete the STarT Back tool questionnaire to support the initial referral.
- 3.2.6 The Provider shall ensure that prescribing, administration and supply of medicines should be initiated for all treatment that is urgent or require immediate attention i.e. any treatment necessary within 7-10 working days. In all other circumstances, any non-urgent recommendations should be communicated back to the GP within 5 days by email or letter. The clinic letter shall be legible and shall state the patient management plan including any changes in medication including any that have stopped or initiated. Prescribing should follow local guidelines and formularies and ensure legal and clinical governance in safe storage, supply prescribing and administration of medicines.
- 3.2.7 If medicines are to be prescribed or administered the provider shall seek their own professional advice to ensure compliance to legislation on safe supply, storage and administration of medicines and make appropriate provision to use Patient Group Directions, pre-packs or prescribing within a clinical governance framework. The Provider shall prescribe in line with the South Staffordshire formulary.

3.3 Care Pathway

Accessing the Service

- 3.3.1 The Provider shall deliver appropriate triage of MSK referrals within 5 working days to ensure that patients are seen in the right place, by the right person at the right time and actively manages inappropriate referrals.
- 3.3.2 The Provider shall offer an initial appointment no more than 3 weeks and 6 days after the patient has opted into the service. Which may lead onto an assessment (face to face or telephone) diagnostics or treatment. Where patients have chosen to wait longer then this will need to be evidenced to the Commissioners.
- 3.3.3 The Provider shall ensure the choice, referral and booking conditions are in line with Service Condition 6 of the main contract.
- 3.3.4 The Provider shall arrange diagnostic tests for all Service Users who have not received the required diagnostics before entering the service where clinically appropriate.
- 3.3.5 Referrals will be rejected where the information contained in the referral is not enough to decide on the appropriateness, including exclusion of red flag symptoms or signs or those that do not meet the criteria for the MSK Service. Referrals will be returned to the source of referral, with reason for rejection, within one week of receipt.

- 3.3.6 Service Users shall be given a choice of appointment date and times. Service Users who do not attend (DNA) the service will not be offered a second appointment and the referral will be returned to the GP; however, the Provider must provide assurance that the patient has received and accepted the original appointment. The provider shall not be paid for DNA's, the MPFT DNA Policy will be followed.
- 3.3.7 The Provider shall ensure that the service is available for patient consultations 52 weeks per year, with the exception of bank holidays. The Service shall be available a minimum of 5 days and between a range of hours offering extended hours per week between 8am-6.30pm and will also include extended hours, for example evenings and Saturday mornings.

Onward Referral

- 3.3.8 The Provider shall ensure that all Service Users who have received an intervention with the service and require a surgical opinion are referred.
- 3.3.9 If surgery is likely to be required the Service User will undergo a basic pre-assessment, to determine fitness for surgery and be offered a choice of surgical provider. Prior to this the Provider shall adopt shared decision-making principles to ensure the patient is fully aware of their options. Where applicable the Service User shall be directed to the Right Care decision ids: <http://sdm.rightcare.nhs.uk/pda/>

Post treatment complications

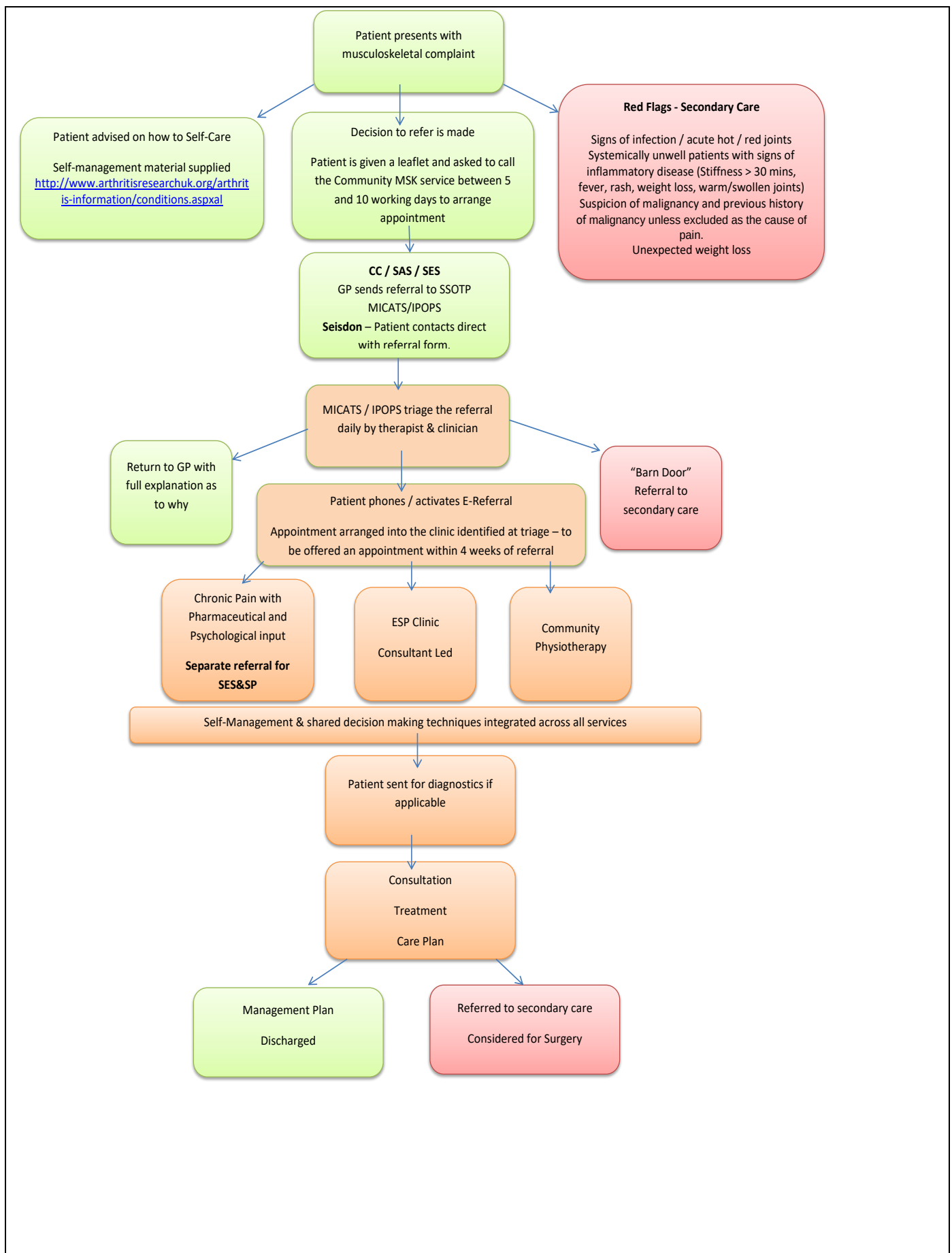
- 3.3.10 The management of complications such as wound infection procedures undertaken by the Provider shall be the responsibility of the Provider. These Service Users will be seen as an emergency at the next available clinic appointment if clinically appropriate and should secondary care management be necessary the Provider should liaise with secondary infection rates will be reported to the Commissioner.
- 3.3.11 The Provider shall have in place developed policies and appropriate equipment at the sites at which services are provided to be able to deal adequately with medical emergencies which might occur (e.g. anaphylaxis).

Discharge Requirements

Please refer to service condition 11

Patient Pathway

The provider will follow the pathway outlined below until the new MSK pathways new Staffordshire wide pathways are implemented from the 1st December 2017.



GP Links / Education

- 3.3.12 The provider shall provide clinical education to other health professionals within the CCG localities.
- 3.3.13 The Provider shall ensure that they offer advice and guidance to clinicians who are unsure of whether a patient requires a referral.
- 3.3.14 The Provider shall build relationships with local GP Practices and work towards having named physiotherapists working with a cluster of practices. The GP link Physiotherapists shall work as part of a multi-disciplinary team approach across their cluster of General Practices and be responsible for an active case load.
- 3.3.15 The Provider shall build relationships and clear pathways with secondary care consultants to ensure patients who require onward referral for surgical opinion are:
- Medically optimising the patient's condition prior to procedure;
 - Assessing the risk and fitness for surgery prior to referral

3.4 Population covered

- 3.4.1 The Provider shall provide services to all Service Users registered with a General Practitioner in Cannock Chase Clinical Commissioning Group (CCG) Stafford and Surrounds CCG for whom the Commissioner is responsible for funding healthcare services.
- 3.4.2 For clarity in the main referrals from Cannock Chase CCG & Stafford & Surrounds CCG shall be treated under the MICATS service and South East Staffordshire and Sesidon CCG patient shall be treated under the IPOPS service. However patients may choose to go to either service where it is geographically closer.

3.5 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

3.5.1 Any Musculoskeletal condition for but not limited to:

- Ligament injuries
- Sprains and strains
- Over-use injuries
- Chronic Pain Management (for SES&SP patients a referral will go direct to the service)
- Osteoarthritis
- Acute & Chronic (three+ months duration) Back Pain & Neck Pain
- Osteoarthritis

3.5.2 These conditions will be treated for the following areas:

- Upper limb
- Lower Limb
- Spinal
- Foot & Ankle
- Hand & Wrist

For the avoidance of doubt this service will accept patients 12 & above until the new provision is provided for the 12-15 year olds and from that point 16+

Service Exclusions

- Any patient that is not registered with one of commissioners GP Practices.
- Patients who display red flag symptoms which include (but not exclusive) to be referred direct to secondary care:
 - Signs of infection /acute hot/ red joints
 - Systemically unwell patients with signs of inflammatory disease (stiffness > 30 mins, fever, rash, weight loss, warm/swollen joint)
 - Suspicion of malignancy and previous history of malignancy unless excluded as the cause of pain.
 - Unexpected weight loss
- Symptoms of cauda equina syndrome (saddle anaesthesia, bladder and/or bowel dysfunction)
- Community Podiatry / Podiatric Nail Surgery
- Specialist Orthotics
- Suspicion of fracture or dislocation
- Severe joint instability
- Haemarthrosis
- Re-referral for chronic conditions, without new symptoms reported.
- Stand alone acupuncture requests
- Vertigo
- Bells Palsy
- TMJ problems
- Chronic fatigue/Fibromyalgia
- Obstetric pain and SPD in IPOPS SES – usually referred to Specialist Obstetric Physio at Queens
- Post natal back pain within 3 months of birth or non-specific back pain of less than 2 weeks.
- Replacement collars and futura splints
- Respiratory
- Neurological
- Fallers/Mobility Assessments
- Inflammatory joint disease
- Patients who have experienced violent trauma, unless fracture has been excluded.
- Surgical Rehabilitation including private patients
- Patient who require a second surgical opinion
- Complex Feet will be seen in the MICATS service only

3.6 Interdependence with other services/providers

- 3.6.1 The Provider shall work in an integrated manor with the following NHS and Independent sector agencies: Acute & community care providers; Independent Diagnostic Providers; Social services and 3rd sector organisations, Patient groups, GPs, Keele University / Research Networks, Public Health, Mental Health providers, Equipment stores, Employers & Job Centre plus, Education providers, Patient Transport and other community services.
- 3.6.2 The service shall have seamless pathways into the other services provided under separate contract with the commissioners, e.g. the pain management service.

3.7 Research

- 3.7.1 The provider shall engage with research projects funded by NIHR (National Institute for Health Research), NHS or educational providers.
- 3.7.2 The provider shall promote research and innovation and the use of research evidence. The provider may also have to facilitate access for University Researchers. The provider shall comply with the Research Governance Framework for Health and Social Care

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 clinical guidance 96 “Neuropathic Pain – The pharmacological management of neuropathic pain in adults in non-specialist settings
- NICE clinical guidance 88, “Low back pain: Early management of persistent non-specific low back pain”
- The British Pain Society and the Royal College of General Practitioners (2004) “ A practical guide to the provision of Chronic Pain Services for adults in Primary Care.”
- Osteoarthritis: Care and management in adults, NICE guidelines [CG177] Published date: February 2014
- Osteoarthritis, NICE quality standard [QS87] Published date: June 2015

4.2	Applicable Standards Set Out in Guidance and/or Issued by a Competent Body (e.g. Royal Colleges)
	- British Pain Society (2007) "Recommended guidelines for Pain Management Programmes for adults." - DH (2006) Musculoskeletal Service Framework: a join responsibility – doing it differently - DH (2008) High Quality Care for All – NHS Next Stage Review Final Report - DH (2011) Safeguarding Adults
4.3	Applicable Local Standards
	- Excluded and restricted Procedures (ERP) previously know as Procedures of Low Clinical Value Policy relating to the MSK condition and pain management. http://www.staffordsurroundscg.nhs.uk/our-services2/erp
5.	Applicable Quality Requirements and CQUIN Goals
1.4	Applicable Quality Requirements (See Schedule 4A-C)
5.2	Applicable CQUIN Goals (Not Applicable, CQUIN Value inclusive of 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.

B. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	SSN_01
Service	Special School Nursing
Commissioner Lead	Kathryn Whitfield, Commissioning Manager • NHS Stafford and Surrounds CCG • NHS Cannock Chase CCG • NHS East Staffordshire CCG • NHS South East Staffordshire and Seisdon Peninsula CCG • NHS North Staffordshire CCG
Provider Lead	Claire Bailey
Period	1 September 2018 – 31 March 2021
Date of Review	As and when required by either Commissioner or Provider

1. Population Needs

1.3 National/local context and evidence base

The Department of Health, together with the Department for Education and key stakeholders have developed a new model for school nursing 'Getting it right for children, young people and families' (updated 2015). <https://www.gov.uk/government/publications/getting-it-right-for-children-young-people-and-families> this includes a focus on:

- a commitment to create a strengthened, rejuvenated workforce
- quality improvements in the school nursing service
- improved health outcomes for children, young people and families
- improved partnership working between school nurses and schools.

The Supporting Pupils at School with Medical Conditions document (Department of Education) <https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3> highlights both statutory guidance and non-statutory advice and encourages joint working between health and local authorities in respect of provision for children with special educational needs and disabilities.

The provider will also need to be aware of the National Healthy Child Programme <https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning> and the interface between clinical management and public health responsibilities.

1.4 Local Need

Special Schools & School Population

Staffordshire has a number of Special Schools located across the County. The majority of the schools provide generic support to children and young people with a range of Special Educational Needs (SEND). Some children and young people in these schools will also have additional needs relating to their physical and mental health. In Staffordshire four schools have specialist provision for children / young people with a Physical Disability (PD) and three have specialist skills in supporting children young people with Behavioural, Emotional, Social Difficulties (BESD). Between them, the schools provide education and support for approximately 2475 children and young people (**Table 1**).

The table below identifies school by CCG area. However, some children and young people will travel from their 'home' CCG to attend a school which can meet their particular needs.

Table 1: Special Schools covered by this specification, at a point in time:

School no	School name	Age of Students	Specialism of School	No.	CCG *
7000	Chasetown Community School admitting pupils from 7-13 years of age with social, emotional and mental health needs	Middle School	Behavioural ,Emotional and Social Difficulties	83	Cannock Chase CCG
7001	Walton Hall Academy, Stafford	High School	Support for children with Special Educational Needs	189	Stafford and Surrounds CCG
7003	Horton Lodge Community Special School	Primary School	Physical Disabilities	58	North Staffordshire CCG
7006	Cicely Haughton Community Special, Wetley Rocks	Primary School	BESD	50- no change	Staffordshire Moorlands CCG
7015	The Fountains High School, Burton	High School	Generic	166 207	East Staffordshire CCG
7016	The Fountains Primary School, Burton	Primary School	Generic	121 200	Stafford and Surrounds CCG
7023	Hednesford Valley High School	High School	Generic	157 184	Cannock Chase CCG
7024	Loxley Hall School, Loxley, Uttoxeter (includes Loxley Hall Armitage)	High School	BESD	92 101	East Staffordshire CCG
7026	Blackfriars School	High School	Generic (PD)	91 111	North Staffordshire CCG
	Newfriars College	College (16-25)	Generic (PD)	153 180	North Staffordshire CCG
7027	The Coppice School, Newcastle	High School	Generic	103 reduction 100-	North Staffordshire CCG
7028	Meadows Special School, Leek	High School	Generic	110 126	North Staffordshire CCG
7030	Two Rivers High School, Tamworth	High School	Generic	165 219	South East Staffordshire and Seisdon Peninsula CCG (SES&SP) Staffs
7032	Sherbrook Primary School, Cannock	Primary School	Generic	129 134	Cannock Chase CCG

7033	Springfield Community Special School, Leek	Primary School	Generic	54 65	North Staffordshire CCG
7034	Cherry Trees School, Wombourne	Primary School	Generic	41 55	(SES&SP)
7036	Rocklands School, Lichfield	Primary School	Generic	124 126	(SES&SP)
7037	Marshlands Special School, Stafford	Primary School	Generic	86 111	Stafford and Surrounds CCG
7038	Merryfields School, Newcastle	Primary School	Generic	111	North Staffordshire CCG
7039	Saxon Hill Community Special & PDSS, Lichfield	All age	PD	94 121	(SES&SP)
7041	Queen's Croft High School, Lichfield	High School	Generic	209 208	(SES&SP)
7042	Two Rivers Primary School, Tamworth	Primary School	Generic	117 132	(SES&SP)
7043	Wightwick Hall School, WV6 8DA	High School	Generic	71 91	(SES&SP)
7750	Greenhall Nursery, Stafford	Nursery School	PD	34 21 reduction	Stafford and Surrounds CCG
	Staffordshire			2531	

1.5 Broader Information regarding the needs of Children & Young People in Staffordshire

The Joint Strategic Needs Assessment for Staffordshire sets out some of the health and wellbeing needs for Children and Young People. The full document can be accessed at:

<http://moderngov.staffordshire.gov.uk/documents/s94660/Childrens%20JSNA%20FINAL%20April%202017.pdf> updated one is 2021- looks at increase wiin YP with weight issues/ mental health/increase in LAC. Also SEND cases growing faster than national average

Whole System Children's Transformation approach - to improve outcomes for children, including the adoption of a strengths-based culture and practice. This will lead to the first example of integrated education and social care place-based teams in the country.

Supporting this are a range of profiles and additional data relating to children and young people which are available at:

<https://www.supportstaffordshire.org.uk/news/staffordshire-observatory>

The Service is expected to keep abreast of any changing needs of the children and young people population in Staffordshire and ensure that it is agile and responsive to meet this.

Regular, local insight from children, young people and their families should be fed into this process and drive ongoing service improvement and development.

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

Children and young people attending Special Schools need to be appropriately supported in their school environment in order that they can play a full and active role in school life, remain healthy and achieve their academic potential. Many of these children will have a medical condition (or a range of conditions) which require effective clinical management as part of their school life.

This will include but is not exclusive to the clinical management of:

- Acute short term conditions.
- Long term conditions.
- Complex needs and disability including children receiving 'continuing care packages'.
- Life limiting and life threatening conditions.
- Emotional and mental health support for pupils and families

North Staffordshire CCG, Stafford and Surrounds CCG, Cannock Chase CCG, East Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG wish to commission a service to deliver integrated clinical services for children educated in Staffordshire Special Schools and achieve the following outcomes:

The Special School Nursing Service will work collaboratively with schools, parents, carers, children and young people and other professionals involved in children's care to ensure:

- Children and young people have their physical and emotional health needs met and are supported to attend school, where this is clinically appropriate.
- Children, young people, schools and families are signposted to other services as required.
- Communication with families will enable successful transition back to school following any period of ill health, where this is clinically appropriate.
- A model of care will be delivered that applies a consistent approach to support children, young people and families resulting in the ability to address specific health related needs, which may be complex in nature.
- The management of conditions will contribute to preventing avoidable admission, attendance or re-admission/re attendance to secondary care.
- Children and young people with health needs are supported to self-manage their condition where appropriate, promoting independence.
- Children and young people are effectively supported at points of transition.
- Safeguarding of children and young people will be effectively co-ordinated and managed.
- Each child/young person will have the health element of their care plan completed and regularly reviewed
- Training and education to partners of health related tasks
- A quarterly report will be produced for commissioners, which will include children, young people and staff feedback.

3. Scope

3.1 Aims and objectives of service

This aim of this service is to:

Support children and young people attending Special Schools in their school environment in order that they can play a full and active role in school life, remain healthy and achieve their academic potential.

The objective is to provide:

- Direct clinical management including emotional health needs and support for Children and Young People with Special Educational Needs and Disabilities (2-25 years) educated in Staffordshire Special Schools including nursing interventions.
- Where necessary providing the training and competencies to education or other staff to support the health needs of any child or young person educated in a Staffordshire Special School.
- Consider out of area work here ? need to add in or represent as a gap in provision
- Where to independent special schools fit into this specification – lots of new ones who do refer into the service but we cannot accept on current provision . ?? unknown numbers potentially large

3.2 Service description/care pathway

This service shall provide high quality responsive clinical and emotional management and support for children and young people educated in Staffordshire Special Schools, whilst in the school setting.

Clinical management will include, but is not exclusive to the management of:

- Acute short term conditions
- Long term conditions
- Complex needs and disability including children receiving ‘continuing care packages’
- Life limiting conditions.

Emotional support will include, but is not exclusive to:

- Assessment and referral to tier 2 providers
- 1:1 tier support in school
- Group work related to SRE/PSHE and emotional well-being
- The service will develop professional partnerships to contribute to seamless provision for children and young people receiving support.
- The service will provide nursing interventions and where necessary training and skills to support health needs of any child or young person educated in a Staffordshire Special School.
- All elements of support require and should incorporate: risk assessments, troubleshooting, infection control, safe practice, training and skills, awareness training, updates, safeguarding children and vulnerable adults.

3.2.1 Assessment and Care Planning:

The Service will provide:

- Holistic assessment of all children and young people’s health needs, which identifies needs and any support that requires intervention and/or referral.
- A care plan will be completed for any clinical interventions which need to be supported in school. The care plan will be completed in partnership with the child/young person, parents, carers and school to identify how clinical needs can best be met.
- Appropriately trained staff will complete individual health assessments, reviews, and care plans which support the individual health needs of children and young people, including the contribution of health information for Initial Health Assessments for Looked After Children and completion of Review Health Assessments for children attending the school
- Children who have Special Educational Needs may require an Education, Health and Care (EHC) Plan. The Service will contribute to the health assessment by providing relevant information in line with statutory requirements i.e. six weeks from the date of request being received.
- Appropriate support to Care Planning for School trips.

Examples of clinical needs which require care planning:

There are a range of conditions which require care planning including and not limited to significant allergies, asthma and respiratory conditions, epilepsy support, diabetes management, shunt care planning, support with very specialist conditions, eczema, airways management, oral suctioning, oxygen, medication and emergency medication.

It is also not unusual for children in special schools to experience multiple conditions.

Where tasks are deemed appropriate to be delegated, a skills based training package will be put in place and reviewed every 6/12 months depending upon procedure.

Not all care plans will be the responsibility of this service, for example children with a specialist nurse. For example a CYP attending a special school receiving a complex care package

3.2.2 Support and Advice

The Service will provide:

Dietary advice/review:

- Support for appropriate assessment of dietary needs and liaison with dietician (where involved) regarding nutritional assessment, initial care plan and ongoing monitoring, working closely with child, family and school. Referral will be made to dietician as required.

Enteral feeding patients:

- Support the implementation of enteral feeding packages in the school setting by delivery of Enteral Feeding skills to ensure safe and effective care takes place (provision of Enteral Feeding is not the responsibility of the Special School Nursing Service).
- Support with implementation of enteral blended diets administration in line with most recent policies and guidance
- Liaison with dietician regarding feeding regimen and ensure up to date appropriate documentation is in place and completed correctly
- Ensure all staff trained maintain skills to deliver enteral feeds.
- Ensure interventions are in line with infection control and are safe and effective.

Medicines Management

The service will support implementation of medication packages in the school setting to ensure safe and effective care takes place. This will include:

- Liaison with prescriber and school where required regarding any drug regime including rescue regimens in accordance with patients treatment/care plans.
- Monitoring as required of height weight, and BP.
- To support education staff with testing following training from specialist service .
- Completing any required risk assessments for the administration of medications within the school setting
- Supporting young people to manage their own conditions and the treatment packages they are receiving and supporting independence with self-administration where this is safe and appropriate.
- Monitor health impact and effectiveness of medication (such as height, weight, blood glucose/ketones) as required in treatment/care plan and refer to GP/specialist as necessary.
- Ensure all relevant documentation is completed as per policy and best practice guidance such as medication charts

Continence

The service will:

- Undertake Continence Assessments for children and young people in Staffordshire Special Schools requiring continence support and place orders for appropriate products.
- Put in place care plans for toilet training and advice and support.
- Support implementation of continence/ bowel management packages in Staffordshire Special Schools to ensure safe and effective care takes place.
- Produce care plans, monitor health impact and refer to specialist as required.

- Implement Bowel Management – liaising with constipation clinics as required.
- Liaise with any relevant Nurse Specialist as appropriate.
- Develop nursing skills and speciality within the team to lead on continence and provide peer training and education
- Provide training for education staff to provide pro active continence support
- Provide support and education to parents/carers and families

Enuresis

The service will:

- Provide assessment of Enuresis.
- Advise on and order bed wetting products e.g. alarms if required.
- Liaise with GP if required e.g. with prescribing medication in-line with local prescribing formularies and guidelines.
- Liaise with any relevant Nurse Specialist as appropriate.
- Develop nursing skills and speciality within the team to lead on enuresis and provide peer training and education
- Provide support and education to parents/carers and families
-

Respiratory Support: (also oral suctioning, Oxygen Therapy, Saturation Monitoring)

The Service will:

- Support implementation for respiratory packages in school to ensure safe and effective care takes place.
- Liaise with respiratory nurse specialist, or leading consultant
- Ensure interventions are in line with infection control and are completed safely and effectively
- Undertake completion of risk assessments
- Deliver skills training and review as required (minimum 6 months).
- Supporting completion of recording of Oxygen saturation, oral suctioning requirements .

Long Term Conditions (LTCs)

The Service will provide support for long-term conditions, including, but not restricted to Diabetes, Asthma, and Epilepsy. This will include:

- Support implementation for management packages for long term conditions in school to ensure safe and effective care takes place.
- Liaison with specialist following a request to monitor health impacts of LTCs and referral on as appropriate.
- Liaison with Nurse Specialists, lead consultants, GPs as required.
- Skills Training for Education staff for administration of medication e.g. Epilepsy rescue administration.
- Supporting children and young people to self-manage their condition.
- Training and cascading information to educational staff on conditions.
- Ensure any interventions are in line with infection control and are completed safely and effectively.

Behaviour and Emotional Support

The Service will provide:

- Signposting to information, advice and support as appropriate .
- Provide Tier 1 support to children young people and families

- Referral onto appropriate services and provide any co-management and work required e.g. Tier 2 Emotional and Behavioural Support, Child and Adolescent Mental Health services (CAMHS) , Paediatric Services, Community Learning Disability Services, as appropriate.

Special Educational Needs and Disabilities (SEND)

The service will take into consideration and respond to any requirements as part of the SEND Guidance <https://www.gov.uk/government/publications/send-code-of-practice-0-to-25> relevant to their role.

The Service will provide advice and support children and young people, their parents and carers regarding arrangements for the assessment and provision of SEND. Special Educational Needs (SEND) legislation requires that the needs of children and young people with Special Educational Needs should be considered up to age 25, in some cases older young people will remain in a special school setting beyond their peers in mainstream schools.

The Service will ensure that relevant information is included in the Staffordshire Local Offer including transition arrangements and that this information is kept up to date.

<https://www.staffordshireconnects.info/kb5/staffordshire/directory/localoffer.page?directorychannel=5>

Continuing Care

The service will provide:

- Support and information for children and young people, parents and carers when children and young people are being assessed for Continuing Care eligibility.
- Information for the Continuing Care assessment process including supporting the collection of evidence and completion of Decision Support Tool (DST) and any other.

3.3 Safeguarding

The service will:

- Work to national safeguarding policies, procedures and guidance including statutory guidance 'Working Together to Safeguard Children' (HM Government 2018) and to Staffordshire Safeguarding Children Board (SSCB) policies, procedures and guidance or Staffordshire and Stoke On Trent Partnership Adult Safeguarding Board (SSASPB) policies, procedures and guidance
- Implement an Early Help approach to supporting children and their families in order to promote wellbeing and prevent harm.
- Be competent in the identification of potential indicators of abuse or neglect and refer to Children's Social Care when a child is at risk or likely risk of significant harm or refer to Adult Social Care when an adult with care and support needs is considered to be abused or neglected.
- Take the role of lead professional as required.
- Work jointly and in partnership with the wider local health economy safeguarding team to utilise a holistic health assessment tool for children and young people subject to a Child in Need (CIN) or Child Protection Plan (CPP) that can be used for evidence in terms of quantifying the child or young person's health needs and associated care plans.
- Be aware of and maintain records of children known to the service with an Early Help Assessment, Child in Need, Child Protection or Looked After Child plan. To work with Designated and Named Nurses/ Doctors, providing health assessments and reports as required.
- Actively contribute to multi-agency decision making, assessments, planning and interventions relating to children in need, children at risk of harm or looked after children.
- Where the child is known to the service, the relevant lead clinician will attend and contribute to child protection conferences, core groups, Child in Need meetings, multi-agency strategy meetings and Looked After Child Health Reviews, where they are the most appropriate health lead and a health perspective will add value.
- Staff should receive appropriate supervision of their most vulnerable caseload. This will include children on a Child Protection Plan, Children in Need, Looked After Children and those children where there are welfare and safety concerns. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection such as the Named Nurse for Safeguarding.

3.4 **Transition**

- The service shall build and maintain links with appropriate professionals to ensure effective communications are in place for Children and Young people transferring to special schools with special education needs and disability or complex health needs so that the special school nurse can safely support the identified clinical needs of the Children and Young people whilst in school.
- The service shall develop pathways to ensure multi-disciplinary care planning processes are in place for a young person transitioning from one setting or to age appropriate services e.g.
 - Special school to mainstream school.
 - Special school to Special school e.g. primary to secondary
 - Mainstream to Special School
 - From Special School to post 16 provision/college and/or to adult services in order to support future independence and self-care as required.
 - All children attending Staffordshire Special Schools will have a year 9 transition review and have a transition action plan devised where needed

The provider should consider the use of good practice documentation for transition as appropriate e.g. 'Ready, Steady, Go'.

<http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx>

3.5 **Population covered**

Special School Nursing Service (incorporating continence and enuresis)

This service covers children and young people registered with a GP in one of Stafford and Surrounds CCG, Cannock Chase CCG, South East Staffordshire and Seisdon CCG, East Staffordshire CCG and North Staffordshire CCG. The child or young person will also be aged 0-25 years **and educated in a Special School** within one of the 5 CCG areas. *

**A cohort of Stoke-on-Trent CCG registered children do attend some of the Special Schools included in this specification, these children ARE also covered by this specification.*

Special Educational Needs (SEND) legislation requires that the needs of children and young people with Special Educational Needs should be considered up to age 25, in some cases older young people will remain in a special school setting beyond their peers in mainstream schools.

<https://www.gov.uk/government/publications/send-code-of-practice-0-to-25>

The service will be available to all Children and Young people in the above cohort without regard to gender, sexuality, religion, ethnicity, social or cultural determinants.

Children and Young People who are not the commissioning responsibility of Staffordshire Clinical Commissioning Groups but who are in receipt of clinical support within special schools in Staffordshire, will be the financial responsibility of the relevant Clinical Commissioning Group.

<http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>

The Provider will ensure that any coverage or boundary issues that may arise will be dealt with proactively in collaboration with neighbouring Providers and Commissioners. Delivery of a service that meets the needs (including safeguarding) of the Child or Young Person must take precedence over any boundary discrepancies or disagreements.

3.5.1 Any acceptance and exclusion criteria.

First Aid

- The provider is not expected to respond to routine first aid needs which can be met by First Aiders within the school setting.

Hours of operation

- The service will be available through term time and the 'normal' school day.
- The service will not routinely be available outside of normal school educational provision e.g. sleepover clubs, residential and holiday or weekend periods.
- There will be adequate cover and provision to respond appropriately to any safeguarding issues, and other health needs which may arise during school holidays.
- The service will respond to EHC /Care Plans as appropriate, minimising delay during school holiday periods.

3.5.2 Response time and Prioritisation

- Where a child moves out-of-area and the service is notified the provider must ensure that the child's health records are transferred to the equivalent provision in the new area within four weeks of notification. Direct verbal contact must be made with the equivalent service to handover a child in need, those on child protection or looked after cases. Systems should be in place to notify appropriate agencies of Children whose whereabouts are unknown.

3.5.3 Interdependence with other services/providers

The service will co-ordinate with other community and public health services, as required and within the best interests of children.

The Service will link closely with others including (list not exhaustive):

- **Local Authority** – Safeguarding teams, , Multi-Agency Safeguarding Hubs, Families First, Locality Teams, Children's Centre services, District Council provision, Education, Health Support Service for Looked After Children and Care Leavers in Staffordshire and Public Health provision such as Lifestyle and Sexual Health Services.
- **Health** – Primary Care, Hospital Trusts, community providers
- **Other Partners** – e.g. Schools, Entrust (provides education support services), Pupil Referral Units, Police and Fire Services, Probation, Pharmacies, Further Education and Colleges, Youth Offending, Voluntary Sector Provision and community groups.
- **Partnership Networks** – Staffordshire Safeguarding Children Board and Staffordshire and Stoke on Trent Adult Safeguarding Partnership, Staffordshire Strategic Children's Partnership, Local District Partnerships and the Health and Wellbeing Board.
- **Commissioners** – Local Authority, Clinical Commissioning Groups, NHS England.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- 1.1.1** Primary, secondary and community services should continue to work closely together and meet regularly to review clinical practice and share best practice initiatives.
- 1.1.2** SSN Services will meet the priorities and outcomes of the Staffordshire Children, Young People and Families Strategy 2016-2026
- Starting well
 - Growing well
 - Living Well
- and
- Happy and healthy

- Safe and belongs
- Achieves and contributes

1.1.3 Record keeping, data collection systems and information sharing

- In line with contractual requirements, the Programme will ensure that systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data. Once in law, the service will comply with the General Data Protection Regulation (2018)
- In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies including other health care Providers, Children's social care and the Police to enable effective holistic services to be provided to Children and their families.
- Appropriate records will be kept in the Child Health Information System to enable data collection to support the delivery, review and performance management of the service.
- Providers will ensure that all staff have access to information sharing guidance including sharing information to promote the welfare and safety of Children or Young People.
- Data collection systems must be effective and efficient and where possible electronic.
- The delivery should be welcoming, friendly and maintain confidentiality at all times.

1.1.4 Recruitment and Workforce Development

The Provider will:

- Be responsible for the recruitment, training, support, management, appraisal and supervision of staff working within the organisation and the overall management of the Service.
- Follow best practice recruitment standards, including staff having enhanced DBS (Disclosure Barring Service) checks annually checked and for those staff with a nursing or other professional qualifications meeting the requirements of professional registration.
- Need to be assured that all the activities and support interventions are delivered by staff who (whether directly employed, volunteers or employed by subcontracting Providers) have capacity and capability to deliver the relevant activity safely and to high quality, including a rationale to support safe staffing levels at schools with the most complex pupils.
- Ensure that the skill mix within the workforce reflects the needs of the service including any administrative staff.
- Develop robust workforce development plans to support full recruitment into all posts in the service. The provider will structure the service staffing in a way which meets the specification outcomes, maximises recruitment and minimises vacancies.
- Ensure staff receive effective and appropriate supervision (see also Clinical Governance 4.1.6).
- Ensure staff meet their Nursing and Midwifery Council (NMC) revalidation and annual Continuing Professional Development (CPD) requirements including safeguarding, equality and diversity.
- Ensure staff delivering clinical support and interventions to Children and Young People with Special Educational Needs and Disabilities will be appropriately qualified, trained and supported in the delivery of these services.
- Ensure staff receive appropriate training to utilise all equipment safely.
Ensure staff receive appropriate training to deliver the commissioned service within clinical and safeguarding guidelines and that this training will be updated and delivered as required.

1.1.5 Delegation and Skills

Registered nurses have a duty of care and a legal liability with regard to the patient. If they have delegated an activity they must ensure that it has been appropriately delegated.

The Nursing and Midwifery Council (NMC) Code (2015) states in the section entitled 'Practise effectively' that registrants must:

Be accountable for the decisions to delegate tasks and duties to other people

To achieve this, they must:

- only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
- make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and
- confirm that the outcome of any task delegated to someone else meets the required standard.

Delegation of duties is summarised in this statement from NHS Wales (NLIAH, 2010):

"Delegation is the process by which you (the delegator) allocate clinical or non-clinical treatment or care to a competent person (the delegatee). You will remain responsible for the overall management of the service user, and accountable for your decision to delegate. You will not be accountable for the decisions and actions of the delegatee."

<https://www.rcn.org.uk/professional-development/publications/pub-006465>

The Provider will ensure:

- A skilled Nursing Team is in place with the knowledge and competence to delegate care to any clinical support worker and educational staff where this is appropriate.
- That an appropriate delegation policy and procedures are in place which meet NMC standards.
- That a competency framework will be in place to support training and education of any clinical support staff or education support staff to meet identified needs including enteral feeding.
- That the framework will include assessment of competency, timescales for review, evidence based training, individual child specific training packages as required.
- That competence assessments will be provided regularly; to ensure all staff completing clinical interventions are competent and safe to do so.
- That enteral feeds assessments will be completed every 6 months, or sooner if indicated.
- That additional training e.g condition specific will be completed and cascaded to educational staff as required.
- The Nursing and Midwifery Code must be followed regarding delegation of tasks.
- The provider must ensure that all activities meet legal requirements, through appropriate clinical governance structures.
- Qualified school nurses will be accountable practitioners to the regulatory bodies in regards to standards of practice and patient care.
- A programme of training and peer support will be in place to ensure staff are appropriately supported to deliver their role effectively and safely.

1.1.6 Clinical Governance

Clinical governance is "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Sally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal 317(7150) 4 July pp.61-6).

Clinical governance covers activities that help sustain and improve high standards of patient care.

The Provider must ensure and be able to show evidence that standards are upheld in a range of areas including:

- Patient focus - how services are based on patient needs
- Information focus - how information is used
- Quality improvement - how standards are reviewed and attained
- Staff focus- how staff are developed
- Leadership - how improvement efforts are planned.

Processes must be in place starting from the Service commencement date to support monitoring of outcomes, evaluation, reporting on improvement, risk management and undertaking audit, parent

feedback, maintenance of safety and quality and professional regulation and clinical supervision. This information is to be reported to the CCGs.

The service will ensure that they are registered and their service offer is detailed on the Staffordshire Local Offer in accordance with the special educational needs and disability code of practice 0-25 years.

4.2 Supervision

The Provider will develop and maintain a supervision and delegation policy and ensure that all staff where appropriate access clinical and safeguarding supervision.

Supervision should be provided by individuals with the ability to:

- Create a learning environment within which the staff can develop clinical skills (where appropriate and within the confinements of this specification) and strategies to support children, young people and their families.
- Provide constructive feedback to teams using advanced communication skills to facilitate reflective supervision.
- Provide guidance on the interpretation of principles and policies to employees working in the service. There should be opportunities for peer review and support.

5. Applicable quality requirements and CQUIN goals

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

5.6 Applicable CQUIN goals (See Schedule 4D).

6. Location of Provider Premises

The Provider's Premises are located at:

- The Service will be delivered across Special Schools in Staffordshire within the school day. There will be reduced but adequate cover in school holidays primarily to ensure safeguarding and contribution to EHC/ Care Plans.
- There will be a base for management of the service within Staffordshire.
- The Service will be accessible, flexible and delivered in Special schools or other venues as appropriate (in exceptional circumstances) and by mutual agreement between families and school nurses.
- The provider makes a commitment to working flexibly if any change to current estate or Special School provision.

Continence and Enuresis

Continence and Enuresis will be delivered in venues as appropriate including schools and in consultation with parents, carers and families. The delivery should be welcoming, friendly and maintain confidentiality at all times.

Appendix 1

Legislative & Policy Context for the delivery of the clinical interventions:

This service specification is guided by the Department of Health/Education documentation:

- Supporting Children at School with Medical Needs (2015)
- Royal College of Nursing: The Future for Community Children's Nursing (2016)
- National Framework for Children and Young People's Continuing Care (2016)
- Special Educational Needs and Disabilities Code of Practice 0-25 years (2015)
- HM Government Working Together to Safeguard Children (2015, updated 2017)
- NHS at home: Community Children's Nursing services (2011)

- National Service Framework (DH, 2010)
- National Framework for Children and Young People's Continuing Care (DH 2010)
- Together for Short Lives (2015)
- Promoting the Health and Wellbeing of Looked After Children: statutory Guidance (DH and DE, 2015)
- Transforming Community Services – Transforming Services for Children, Young People and their Families (2009)
- Department of Health (2011) You're welcome: quality criteria for Young People friendly health services

Evidence base and key policy documents include but is not exclusive to:

- Department of Health and No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages (2011) HM Government
- Department of Education and Health (2014) Guidance on the special educational needs and disability (SEND) system for Children and Young People age 0 to 25, from 1 September 2014.
- Department of Health (2010) Getting it right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs.
- Department of Health (updated 2015) Getting it right for Children, Young People and families – maximising the contribution of the school nursing team: Vision and call to action
- Department of Health (2010) Achieving equity and excellence for Children. How liberating the NHS will help us meet the needs of Children and Young People
- Department of Health (2010) Equity and excellence: Liberating the NHS and Liberating the NHS: Legislative framework and next steps
- Early Intervention Foundation: Getting it right for families. A review of integrated systems and promising practice in early years (2014)
- Field, F. (2010) The Foundation Years: preventing poor Children becoming poor adults. HM Government: London.
- Hall, D. and Elliman, D. (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press.
- HM Government (2013) Working together to safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of Children (updated 2017)
- Marmot (2010) The Marmot Review Strategic Review of Health Inequalities in England
- Public Health England (2014) The Link between Pupil Health and Wellbeing and Attainment. A briefing for head teachers, governors and staff in education settings.

Applicable national standards (eg NICE)

Applicable national and local standards (list not exhaustive)

Key guidance includes:

- QS31 – Health and wellbeing of Looked After Children and Young People: NICE support for commissioning (2013)
- CG89 - When to Suspect Child Maltreatment (Updated 2017)
- NHS Evidence; update 29: Strategies to prevent unintentional injury among Children and Young People aged under 15 (2013)

NICE clinical guidance and quality standard documents relevant to Children and Young People with Special Educational Needs and Disabilities. Some have been listed here as examples, but this list is not exhaustive. There is an expectation that Providers will ensure all staff are aware of relevant guidance and quality standards, including recent updates.

- Transition from children's to adults' services for young people using health or social care services <https://www.nice.org.uk/guidance/NG43>
- NICE Asthma Quality Standard [QS25] (2018)
- NICE Diabetes in Children and Young People Quality Standard [QS125] (2016)
- NICE Epilepsy in Children and Young People Quality Standard [QS27] (2013)
- NICE Bedwetting in Children and Young People Quality Standard [QS70] (2014)

Service Specification No.	SSN_02
Service	Review Health Assessments (RHAs) for Looked After Children: - Staffordshire (excluding Stoke on Trent) Children and Young People aged 0 - 19 (excluding Hard to Reach) - Children and Young People aged under 5 (Stoke-on-Trent CCG only)
Commissioner Lead	Kathryn Whitfield, Commissioning Manager - NHS Stafford and Surrounds CCG - NHS Cannock Chase CCG - NHS East Staffordshire CCG - NHS South East Staffordshire and Seisdon Peninsula CCG - NHS North Staffordshire CCG
Provider Lead	Claire Bailey
Period	1 September 2018 – 31 March 2021
Date of Review	As and when required by either Commissioner or Provider

1. Population Needs
1.1 National/local context and evidence base 1.1.1 There are over 15 million children and young people (CYP) under 20 in England accounting for nearly 25 per cent of the population and of these: 6 per cent have a disability 14 per cent have a long standing illness - Over 10 per cent have asthma 66,000 have autism 60,000 have epilepsy 23,000 have diabetes (Source: Children and Young People's Outcomes Forum, 2015) 1.1.2 The number of looked after children (LAC) has continued to rise; it has increased steadily over the last eight years. There were 70,440 looked after children at 31 March 2016, an increase of 1% compared to 31 March 2015 and an increase of 5% compared to 2012. The rise this year reflects a rise of 1,470 in unaccompanied asylum seeking children, compared to a rise of 970 in all looked after children (Department of Education, 2016). 1.1.3 In 2016 the number of looked after unaccompanied asylum seeking children increased by 54% compared to last year's figures, up to 4,210 children at 31 March 2016 from 2,740 in 2015 and up from a low of 1,950 in 2013. At 31 March 2016, unaccompanied asylum seeking children represented 6% of the looked after children population. 1.1.4 In 2016/17 CYP accounted for 21.8% of the overall population of Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds CCG areas (also known as 'South Staffordshire'). 1.1.5 Many of these looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care

with a worse level of health than their peers often as a result of poverty, abuse and neglect. The aim is the delivery of services from health agencies to ensure the promotion of the health of looked after children.

1.1.6 Looked-after children and young people should expect to have the same opportunities as other children and young people, including being healthy and safe. They should be provided with the opportunities needed to help them move successfully to adulthood.

1.1.7 The needs of looked-after children and young people vary, but are often complex, and can only be met by a range of services operating collaboratively across different settings.

1.1.8 Staffordshire County Council had 994 children in care on the 1st April 2017.

1.1.9 For children and young people who are looked after there is a statutory requirement for 0-4 year olds to receive a biannual review health assessment and 5-18 year olds to receive an annual review health assessment (RHA). The RHA is an important feature of addressing the known health inequalities of LAC and in developing an ongoing care plan to address any health needs arising.

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

2.2.1 Review health assessments (RHAs) are a statutory requirement that Clinical Commissioning Groups are required to provide for Looked After Children (LAC) and should be completed on an bi-annual basis for 0-4 year olds and on an annual basis for children and young people aged 5-18 years.

2.2.2 In order to address the needs of LAC, the provider is expected to:

- Provide an equitable service to the population of LAC that the service covers.
- Allow LAC to be assessed safely in the most appropriate location, including closer to home
- Improve and maintain CYP & parent/carer satisfaction
- Ensure LAC receive a high standard of care and an excellent experience
- Work with other RHA providers to share learning, improve services and reduce variation
- Complete RHAs in a timely fashion (as per agreed timescales).
- Complete RHAs to the required quality standard.
- Share appropriate information with other relevant agencies regarding the needs of the LAC identified within the RHA.
- Contribute towards the reduction in health inequalities experienced by LAC.
- Ensure a holistic approach is taken to address the health, social care and emotional wellbeing needs of LAC

- Identify and act upon any concerns regarding the safeguarding of LAC and reporting of any concerns in line with the Staffordshire and Stoke-on-Trent Local Safeguarding Board policies and procedures. Focus should also be placed on any LAC that is missing from home/care placement.
- Support LAC to increase self-caring abilities and signposting them to a range of local resources that can address any health or social care needs exhibited.
- Facilitate transition arrangements for LAC
- Provide specific guidance to LAC leaving care regarding their health needs. This will be provided in the form of a booklet documenting key aspects of the LAC's health care needs from their period in care.

2.2.3 Existing separate RHA providers are required to work together to achieve a reduction in variation to assist when children move from one group to another (0-4s to 5-18s or from 'hard to reach' to 'non-hard to reach') or from one geographical area to another.

This should include:

- Agreeing a consistent referral and assessment process across Staffordshire and Stoke-on-Trent to allow for cross boundary working if appropriate.
- Development of one shared plan for a child, across the system, where other organisations have an input.

3. Scope

3.1 Aims and objectives of service

3.1.1 The aim of the Review Health Assessments for Looked After Children service is to provide a high quality responsive service to LAC accessible five days a week and should seek to meet the following objectives:

- To work with the relevant Local Authorities to provide coordinated and, wherever possible, integrated services.
- Establish an effective route for communicating the outcome of the RHA with other services (statutory or voluntary) who are providing support to LAC.
- To provide early identification of risk of abuse of LAC who are referred and act efficiently to minimise the risk of children experiencing harm and promote their wellbeing.
- To provide early identification of health needs in LAC who are referred, through the RHA process, offering appropriate advice and support and referral onwards as required.
- Ensure that LAC covered by this specification are supported and their health needs are met safely in an efficient and timely manner.
- To empower families of LAC to lead independent lives.
- To work in partnership with families, carers, education, social care and other health professionals working around the child.
- To improve the health and life chances for LAC.
- To safeguard and promote the welfare of the CYP known to the service, giving recognition to the increased vulnerability of children with complex needs.
- To provide guidance during the RHA regarding health promotion resources, statutory health provision and other sources of health care support that could be accessed by the LAC
- To ensure young people are supported through transition into adult services and/or onward into adulthood.
- To work closely with commissioners of services to develop new services and develop services in line with national and local priorities, consultation with service users and guidance and to ensure high quality, effective and value for money services.

- To provide clear, up to date and accessible information and advice to enable LAC and their families/carers to play an active role in the development and implementation of their care plan.
- To improve and maintain the child/young person/parent/care experience.

3.2 Referral Criteria and Pathway

Referral Criteria

- The CYP must be a Looked After Child (LAC), attendance at a Staffordshire School
- OR
- School age (not 'Hard to Reach') and the responsible CCG is one of:
 - NHS Cannock Chase Clinical Commissioning Group
 - NHS East Staffordshire Clinical Commissioning Group
 - NHS North Staffordshire Clinical Commissioning Group
 - NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
 - NHS Stafford and Surrounds Clinical Commissioning Group
 - NHS Stoke on Trent and the child attends a special school in Staffordshire

Referrals that do not meet the referral criteria will be redirected to the most appropriate service

Referral Pathway:

- Referrals can be made by email to a secure nhs.net account.
- Preliminary triage against the referral criteria should be carried out by the service upon receipt of referral from Staffordshire County Council, and the assessment completed within six weeks of the notification.
- Initial contact is made to the foster carers and the LAC's social worker.
- The RHA is completed with referral to other organisations as required. 'Agreement to share information' should be completed.
- The RHA plan is then agreed with the Child/young person family/carers.
- Referrals to the service can only be made by agreed central hub

3.3 Service description / Care pathway

3.3.1 The Review Health Assessments for Looked After Children service seeks to provide LAC with a holistic assessment of their physical, emotional and behavioural needs, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps. The assessment also includes aspects of health education and health promotion, and is known as a Review Health Assessment (RHA). The core focus of this service is as per the referral criteria.

3.3.2 The service will be expected to:

- Develop professional partnerships ensuring the provision of a seamless service for LAC and their families
- Communicate and liaise with the LAC's Independent Reviewing Officer regarding any concerns highlighted during the process of undertaking a RHA.

- Co-ordinate, facilitate and quality assure RHAs in accordance with protocols. Professionals are accountable for maintaining records to ensure timely reviews are undertaken.
- Engage with appropriate translation services as required by LAC to assist the RHA process.
- Promote registration with a General Practitioner (GP) and support this through the LAC's care setting. A copy of the RHA summary and plan should be sent to the GP that the LAC registers with.
- Ensure and maintain robust internal procedures and systems for monitoring health outcomes for children and young people who are looked after.
- Achieve national performance standards for completing RHAs for LAC.
- Provide any LAC leaving care with a "Leaving Care Health Passport" in all cases KW to send document over to Pam and then will discuss with team at team meeting. To be done age 17
- Support uptake of all screening and immunisation programmes for LAC, alongside national programmes.
- All non-attendance of carers/children and/or young person for their RHA review will be notified to their social worker within one working day and recorded in the child's records Usually inform SW after 3 missed appointments unless concerned

3.3.3 In line with national guidance, all RHAs should include:

- an assessment of the child's state of health including their physical, emotional and mental health;
- the child's health history including, as far as practicable, the child's family's health history;
- the effect of health and health history on the child's development;
- existing arrangements for medical and dental care, appropriate to the child's needs, including:
 - routine checks of the child's general state of health, including dental health;
 - treatment and monitoring for identified health or dental care needs;
 - preventive measures such as inoculation;
 - screening for defects of vision or hearing;
 - advice and guidance on promoting health and effective personal care; and
 - planned changes to current arrangements.

3.3.4 Response Times

- Respond within 6 weeks of notification of a referral for a LAC who requires a RHA.
- Negotiate the time of visit with the child/young person/family/carers
- Notify the family of an attempt to call if they are not in when the nurse visits.
- If a visit or contact is not possible due to service capacity then the Review Health Assessments for Looked After Children service will inform the Local Authority and the CCG.

3.3.5 Care Planning

- Plan, implement, monitor and evaluate programmes of care
- Agree a robust plan of care with the child or young person, parent or carer and multi-agency partners (where necessary) who are involved with the family.
- Develop assessment and RHA plans for children with long term conditions in partnership with family/carers and partner agencies, for all children and young people who are referred to the service.
- Agree a clear management plan based on evidence and informed by national and local protocols, guidelines and pathways
- Provide specialist one to one health advice and support to children and young people in order to promote self-care, where appropriate,

- Provide specialist one to one health advice and support to parents and carers, in order to give them the knowledge and skills to care for the child or young person at home.

3.3.6 Safeguarding

- Work to national safeguarding policies, procedures and guidance and to Locality Safeguarding Children Boards (LSCB) policies, procedures and guidance.
- Be aware of potential indicators of abuse or neglect and to signpost or refer as appropriate. Be aware of and understand the LSCB “Early Help Strategy”

3.3.7 Transition

- Support transition from children’s services to adult services, with a particular focus on children and young people with long term conditions, disability or who have life limiting conditions, making use of nationally recommended tools.
- Develop protocols which take into account the maturity of the young person and their social circumstances and allow for flexibility and scope for choice
- Develop protocols which take account of policies and guidance from Locality Safeguarding Children Boards (LSCB) policies, procedures and guidance.

3.3.8 Continuing Care (Children, Young People and Adults)

- Support transition from children’s services to adult services, with a particular focus on children and young people with long term conditions, disability or who have life limiting conditions, making use of nationally recommended tools.
- Develop protocols which take into account the maturity of the young person and their social circumstances and allow for flexibility and scope for choice
- Develop protocols which take account of policies and guidance from Locality Safeguarding Children Boards (LSCB) policies, procedures and guidance.

3.3.9 Training (Internal and Staff Development)

- Ensure staff receive regular supervision. This can be received through a combination of group and individual supervision sessions. Supervision should be aligned to role responsibilities and needs of service users and their families.
- Ensure staff meet their NMC revalidation and annual CPD requirements
- Ensure staff undertake all mandatory training requirements-including safeguarding, equality and diversity.
- Ensure that all staff receive appropriate up to date training to enable them to utilise all equipment appropriately.
- Ensure that the workforce is able to meet the needs of the service.

3.3.10 Consultation and Service User Engagement

- Develop a range of methods for engaging children and young people to obtain their views on the service.
- Develop a range of methods for engaging parents and carers to obtain their views on the service.
- Feedback the views of children, young people, parents and carers at appropriate intervals but at least once per year

3.3.11 Commissioning Review Health Assessments for Looked After Children Services

- Work with CCGs in the developmental programmes aimed at extending the effectiveness and cohesiveness of local health and social care provision.

3.4 Population Covered

3.4.1 The service covers the following LAC

- All school age looked after children who are educated in a special school where the responsible commissioner is one of the following:
 - NHS Cannock Chase Clinical Commissioning Group
 - NHS East Staffordshire Clinical Commissioning Group
 - NHS North Staffordshire Clinical Commissioning Group
 - NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
 - NHS Stafford and Surrounds Clinical Commissioning Group
 - NHS Stoke on Trent and the child attends special school in Staffordshire
- The service will be available to this LAC population without regard to gender, sexuality, religion, ethnicity social or cultural determinants.

3.4.2 Any acceptance and exclusion criteria and thresholds

3.4.2.1 Exclusions

The looked after children and young people below are covered by separate specifications (Staffordshire Looked after children aged 0-4 and Hard to Reach) (Stoke on Trent Targeted Intervention Service)

- Children and Young People aged over 5 (Stoke-on-Trent CCG)
- Staffordshire CCGs:
 - Children aged under 5
 - All children not in an education setting
 - Children in any other educational setting that is not classified as a special school. Although not exhaustive, this exclusion includes those who are in mainstream schools or home-educated.
 - All children not in school but in a LA or private provider residential accommodation
 - In prison
 - Semi-independent living (16 and 17 years of age)
 - Difficult over the boundary cases placed by the LA that return by request of the social worker for a RHA
 - Unaccompanied asylum seekers
- Any LAC who are the responsibility of a local authority other than ones set out in '3.4 Population Covered' are excluded from this service.

OR

- The LAC requires a final RHA at the age of 17 years

3.5 Hours of Operation

3.5.1 The service will be available 39 weeks per year within the parameters set out as follows:

- A service operates between the hours of 8.30am and 4.30pm, Monday to Friday (core hours) for advice and support and visits as required, but can be flexible to suit the needs of the LAC and their family/carers.

3.6 Interdependence with other services/providers

3.6.1 The service will work collaboratively with all those listed below and any other provider or agency involved in the care of the CYP as required. They will work proactively and collaboratively with these agencies to develop robust pathways of care and provide a holistic service.

- The LAC
- Parents and families
- Other carers
- Primary Care
- General Practice
- Secondary/Tertiary Care
 - Specialist Children's Nurses
 - Acute Paediatricians
 - Neonatologists
 - Specialist Doctors
 - Dieticians
- Community Care
 - School Nurses
 - Health Visitors
 - Looked After Children and Family Nurse Partnership
 - Other providers of children's continuing care packages
 - Physiotherapists
 - Occupational Therapists
 - Speech and Language Therapists
 - Community Paediatricians
 - Specialist equipment suppliers and loan stores
 - District Nurses
 - Speech and Language Therapy Services (SaLT)
- Others
 - Sustain + (commissioned service for LAC with emotional/behavioural concerns)
 - Child and Adolescent Mental Health Services (CAMHS)
 - Learning disability services
 - Other Special School Nursing
 - Autistic Spectrum Disorder (assessment and intervention) Service Providers
 - Families First
 - Education providers
 - Social Workers
 - Specialist Teachers/SENCOs/Classroom Teachers
 - Early Help
 - Preventative services
 - Short break Staff
 - Palliative Care Consultant/Hospice staff
 - Housing Officers
 - Support groups and local voluntary sector organisations
 - National charities
 - Designated Professional Leads for Safeguarding
 - Education settings
 - Staffordshire Police
 - Staffordshire and Stoke on Trent Local Safeguarding Board
 - Providers of registered children's homes

The above is not an exhaustive list of services and providers are expected to work collaboratively with all relevant services and providers who may contribute to the care of the LAC.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.1.1 The Review Health Assessments for Looked After Children service and advice provided should comply with the following key legislation and guidance:

- Relevant NICE guidelines
- Relevant NPSA and MHRA safety guidance / alerts
- Healthy lives, brighter futures – The Strategy for children and young people's health, DH / DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services DH (2006)
- Transition: getting it right for young people
- The National Service Framework for Long-term Conditions, DH (2005)
- Disabled Children and Young People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- Every Child Matters (2003)
- Working Together to Safeguard Children (2015)
- Children Act (2004)
- The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)
- Children and Families Act (2014)
- National Guidance on Continuing Care (Children & Adults)
- SEND Code of Practice 0-25 years June 2014
- Responsible commissioner guidance (2013)
- Care Quality Commission Standards
- Promoting the Health and Well-being of Looked After Children (Department of Education and Department of Health, 2015)
- Children Act (1989) – the framework for providing a comprehensive service and support system for children and their families in need of support and protection;
- Crime and Disorder Act (1998)
- Recommendations from The Victoria Climbié Inquiry Report (2003)
- Safeguarding Children in Whom Illness is Fabricated or Induced (Department for Children, Schools and Families, 2008)
- United Nations Convention on the Rights of the Child (United Nations 1990)
- European Convention of Human Rights Articles 6 and 8
- Adoption and Care Leavers Act (2002)
- Foster Care Regulations (2002)
- 0-18 years guidance for all doctors – General Medical Council (2009)
- Sudden unexpected death in infancy: A multi-agency protocol for care and investigation. (Royal College Path and RCPCH 2004)
- Safeguarding Children and Young People: Roles and competences for health staff. (Intercollegiate document , 2014)
- Staying Safe (Department of Health, 2008)
- You're Welcome (Department of Health, 2007 & 2009)
- The Protection of Children Act (1999)
- Framework for the Assessment of Children and their Families (Department of Health, 2000)
- Sharing Information: Practice Guide (DFES 2006)

The above is not an exhaustive list of legislation & guidance and the provider would be expected to keep up to date with all relevant legislation, guidance and NICE guidance.

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

- 4.2.1** All health organisations must demonstrate how they have listened to the voice of children and young people and how this will be used to improve their health outcomes.

Children and Young People's Health Outcomes Forum (2012)

4.2.2 The Review Health Assessments for Looked After Children service and advice provided should comply with *The Code (NMC, 2015)*

4.2.3 The first assessment must be carried out by a registered medical practitioner while subsequent assessments may be carried out by a registered nurse or by a registered midwife, [regulation 7(3)].

4.2.4 Health assessments should take place:

- at least once every six months in the case of children aged under five; and
- at least once every 12 months in the case of children aged five and over.

The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review (Department for Education, 2015)

4.3 Applicable Local Standards

4.3.1 Review Health Assessments for Looked After service will meet the priorities and outcomes of the Staffordshire Children, Young people and families Strategy 2016-2026

- Starting well
 - Growing well
 - Living well
- and
- Happy and health
 - Safe and belongs
 - Achieves and contributes

4.3.2 The Review Health Assessments for Looked After Children service will be expected to comply with all Trust procedures, policies and practices.

4.3.3 Comply with all Staffordshire and Stoke-on-Trent Local Safeguarding Children Board's policies and procedures.

5. Applicable quality requirements and CQUIN goals

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

1.6 Applicable CQUIN goals (See Schedule 4D).

6. Location of Provider Premises

The service will provided in a variety of settings that are easily accessible and acceptable to looked after children. Given the nature of the proposed users of the service, the provider will be expected to adopt flexibility in how the RHA would be conducted.

Service Specification No.	FSW_01
Service	Frailty* (*Staying Well) Service NHS Cannock Case CCG, NHS Stafford and Surrounds CCG and South East Staffordshire(SES) and Seisdon CCG (SES element only Seisdon covered under separate specification)
Commissioner Lead	Craig Porter, Managing Director (South West)
Provider Lead	Jennie Collier, Managing Director – South Care Group
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

1.1.1

There is an abundance of research into frailty in the elderly population and that people over the age of 65 years old account for 66% of all hospital admissions, and 40% of all emergency admissions.

To improve disease management and related hospital admissions, there is a need for an effective Multi-Disciplinary Team to deliver a frailty pathway and a Staying Well Hub/ MDT clinic-based Frailty service, to support the most appropriate management of service users in the most appropriate setting.

Frailty Factors Known to Contribute to the Hospital Admission in Elderly People Intrinsic:

- Ageing process (risk increases over 65 years)
- Poor mobility
- Cognitive impairment /confusion/agitation (memory loss)
- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status
- Emotional distress/depression
- Social isolation

Extrinsic:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise
- Environmental hazards (steps, stairs, worn carpets, rugs etc.)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing/cooking etc.)
- Social stimulation and community networks

Evidence Base

- Our Health, Our Care, Our Say: A New Direction for Community Services, DoH 2006

- Department of Health (2001) The National Service Framework for Older People, Department of Health, London
- NHS Plan (2006)
- Earlier, risk managed discharge plan = reduction in “bed blocking” days (Ward 2007, RCP 2005)
- Choosing Health, DoH 2004
- The Operating Framework for the NHS in England [2012/13] (or any updated version thereof)
- Shifting Care Closer to Home Policy DoH 2008
- High Quality Care for All DoH 2009
- Codes of Professional Conduct – General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)
- Compliance with CQC Essential Standards of Quality and Safety and appropriately registered with the CQC to demonstrate this.

1.1.3 The NHS Five Year Forward View aims to deliver better health, better patient care and greater efficiency within the NHS. To help support delivery of this vision, Sustainable Transformation Plans (STP) are being written across the health systems to show how providers and commissioners will evolve and become sustainable over the coming years.

2. Outcomes

2.0 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	✓

2.1 Local Defined Outcomes

- The patient and/ or representative shall feel involved in all aspects of their care planning.
- The patient and/ or representative shall feel empowered to make decisions and choices about all aspects of their life, condition, care and services accessed.
- The patient and/ or representative shall feel that they are at all times treated with dignity and respect.
- Enhanced patient and carer experience, independence, satisfaction with the service received and quality of life.
- CCG assumption - Assessment per patient and care plan interventions result in reduced NEL admissions. The ratio of avoided NEL admissions and A&E attendances is assumed to be 0.8 for the best case, with the most likely case estimated at 0.6 of this level.
- Reduction in A&E attendances for patients aged 55 years and over
- Reduction in unplanned admissions for patients aged 55 years and over

2.2 Local Defined Outcomes

The Provider has agreed to adhere to the ‘Evaluation Framework’ for the recording of information and data related to the project performance. Please see Appendix 1 below for full details of framework.

A suitably timed post implementation benefits realisation review needs to be undertaken and the Provider agrees to support this review.

3. Scope

Aims and objectives of service

The aims and objective of the Frailty* (*Staying Well) Services Pilot Project is to deliver a safe and effective Multi-Disciplinary Team (MDT) based service which enables service users to avoid hospital admissions.

The overarching aims, and objectives are to;

- Enhance the patient pathway by effectively managing patients within the most appropriate setting
- Provide fast, timely access to assessment, treatment and care
- Prevent avoidable hospital attendance and admission
- Contribute appropriate data to the system dashboard, which will monitor impact of the service

Service Description

The Frailty* (*Staying Well) Service is recognised as a Pan Staffordshire Service Development and the delivery of a Frailty Model/Pathway with mobilisation of Multi-disciplinary Staying Well Hubs key to the project success.

It is noted that the Staying Well Pilot will develop and mobilise services which are focused in the South of Staffordshire i.e. Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG and Stafford & Surrounds CCG areas. Any wider roll out would be expected to take account of the pilot evaluation and deliver the same outcomes using the same evaluation framework for all service users.

It has been agreed that the all parties will agree to a Memorandum of Understanding with partners to support integrated working please refer to Schedule 5 – Governance, Part A - Documents to be Relied On.

The Provider will carry out their responsibilities in relation to Schedule 5 – Governance, Part C - Provider's Material Sub-Contracts, regarding the subcontracting arrangements to deliver the service.

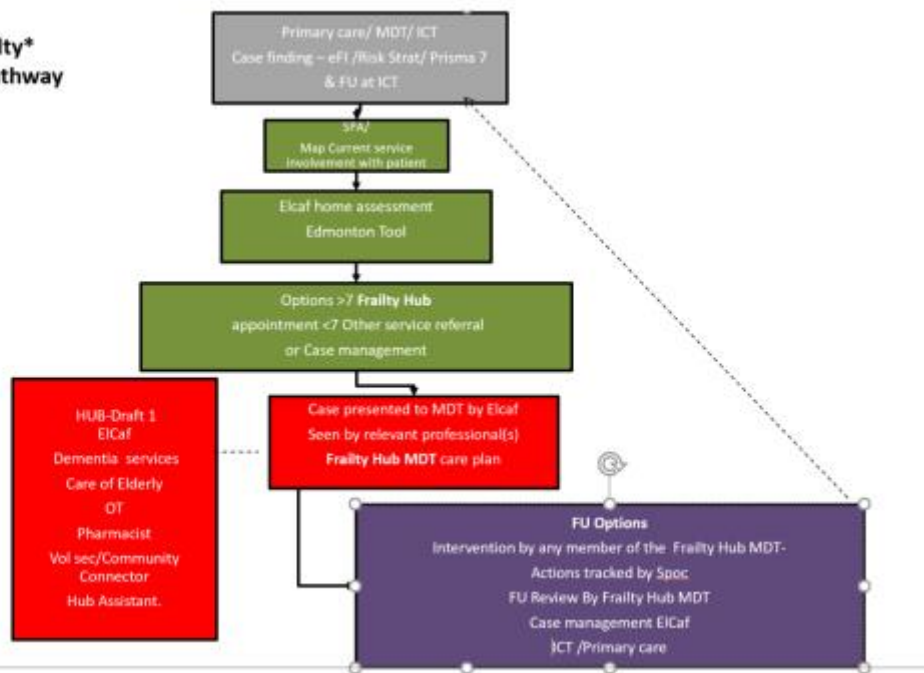
Referral Pathway

- Referral to the service is from GPs and ICT's to include Hubs/ MDT clinics, Locality and alliance level service

Care Pathway

SE phase 1 - Frailty* (Staying well) Pathway

Key
 Primary care
 MPFT
 MD Frailty Hub
 Community or ICT



Each respective CCG has agreed to deliver the following service(s) in order to meet the aims and objectives of the Staying Well Service; the funding will be utilised for System Partners to provide and deliver the following:

- Offer and complete a holistic assessment on those people identified by Primary Care (**Community Provider**) and produce a care plan
- Analyse results of assessment and refer on for case management/ to appropriate services OR refer to Staying Well Hub (or equivalent) for a multi-disciplinary team assessment (**Community Provider and Acute Sector**). Staying Well Hubs will be attended by a Geriatrician and Clinical Pharmacist from the appropriate Acute Trust and will be scheduled according to need and demand.
- Care Plan actions tracked by Single Point of Contact (**Community Provider**)
- Care Plan actions which require GP input to be clearly communicated (**Community Provider**) and actioned (**Primary Care**).

Population Covered

- The service shall initially provide care to any patient who is identified as mild-moderately frail (identified using a ratified tool) and that is registered with Cannock Chase NHS CCG, Stafford and Surrounds CCG, South East Staffordshire & Seisdon Peninsula CCG General Practitioner (GP).
- Identification of frailty is complex but should include electronic Frailty Index (eFI) scoring along with clinical assessment using a validated tool (e.g. Rockwood) and/or based on known clinical history.

Interdependencies with other services

- The Provider will use their specialist expertise to creatively develop safe and effective ways to deliver positive outcomes in collaboration with partners and by building on existing good practice and positive relationships.
- MPFT will support patient access to other relevant services in line with their existing referral criteria as required in accordance with individual needs as below, but not limited to:
 - Allied Health Professions
 - Primary Care/General Practitioners
 - Acute and Community Hospitals
 - Other Community Services E.g. Infection & Prevention Team, Tissue Viability Team, Continence Team, Dietetics Team
 - Exercise Providers
 - Independent sector
 - Voluntary sector
 - Warmer Homes/Beat the Cold Schemes
 - Energy Saving Trust

Workforce

The Service shall be responsible for ensuring that (where relevant) their clinical and / or non-clinical staff are:

- Trained in the agreed Standard Operation Procedures for the service.
- Trained in the use of EMIS (Egerton Medical Information Systems) as the current central information portal for this service

Governance

All Service Providers delivering parts of the pathway will take on full governance responsibility for patients treated. They will ensure that appropriate and adequate medical governance is in place to support the safe and effective delivery of the service.

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.

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

N/A

4.3 Applicable Local Standards

Please refer to Schedule 4c

5. Applicable Quality Requirements and CQUIN Goals

5.1	Applicable Quality Requirements (See Schedule 4A-C)
5.2	Applicable CQUIN Goals (Not Applicable)
6.	Location of Provider Premises
	The Provider shall operate out of a range of premises with locations agreed with the Commissioner and for ease of access for the Service Users.
7.	Individual Service User Placement
	Not applicable.

Service Specification No.	FSW_02
Service	Frailty* (*Staying Well) Service NHS South East Staffordshire(SES) and Seisdon CCG (Seisdon element only)
Commissioner Lead	Craig Porter, Managing Director (South West)
Provider Lead	Jennie Collier, Managing Director – South Care Group
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

1.1.1

There is an abundance of research into frailty in the older population which suggests that people over the age of 65 years old account for 66% of all hospital admissions, and 40% of all emergency admissions.

To improve disease management, related hospital admissions, and outcomes for patients the need for an effective case finding process and pathway for people with mild to moderate frailty was identified. The Staying Well pathway has been developed to deliver the frailty pathway and support the most appropriate management of service users in the most appropriate setting.

These needs above were identified prior to the Covid-19 pandemic. However, patients aged over 55 who are mild to moderately frail as a result of covid 19 infection and/or shielding/social isolation will also benefit from this service.

Frailty Factors Known to Contribute to the Hospital Admission in Elderly People Intrinsic:

- Ageing process
- Poor mobility
- Cognitive impairment /confusion/agitation (memory loss)
- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status
- Emotional distress/depression
- Social isolation

Extrinsic:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise

- Environmental hazards (steps, stairs, worn carpets, rugs etc.)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing/cooking etc.)
- Social stimulation and community networks

Evidence Base

- Our Health, Our Care, Our Say: A New Direction for Community Services, DoH 2006
- Department of Health (2001) The National Service Framework for Older People, Department of Health, London
- NHS Long Term Plan, January 2019
- Earlier, risk managed discharge plan = reduction in “bed blocking” days (Ward 2007, RCP 2005)
- Choosing Health, DoH 2004
- The Operating Framework for the NHS in England [2012/13] (or any updated version thereof)
- Shifting Care Closer to Home Policy DoH 2008
- High Quality Care for All DoH 2009
- Codes of Professional Conduct – General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)
- Compliance with CQC Essential Standards of Quality and Safety and appropriately registered with the CQC to demonstrate this.

Urgent and Emergency Care (UEC) remains a high priority across the NHS as demand continues to increase; resulting in significant rises in Emergency Department (ED) attendances and emergency admissions.

The NHS Long Term Plan identifies the need to reduce pressure on emergency hospital services, focusing on community support and supporting service users at home wherever possible - enabling them to ‘stay well’. The NHS Long Term Plan also includes key themes around Ageing Well, Personalisation and Prevention.

2. Outcomes

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	✓

Local Defined Outcomes

- The patient and/ or representative shall feel involved in all aspects of their care planning.
- The patient and/ or representative shall feel empowered to make decisions and choices about all aspects of their life, condition, care and services accessed.
- The patient and/ or representative shall feel that they are at all times treated with dignity and respect.
- Enhanced patient and carer experience, independence, satisfaction with the service received and quality of life.

- CCG assumption - Assessment per patient and care plan interventions result in reduced NEL admissions. The ratio of avoided NEL admissions and A&E attendances is assumed to be 0.8 for the best case, with the most likely case estimated at 0.6 of this level.
- Reduction in A&E attendances for patients aged 55 years and over
- Reduction in unplanned admissions for patients aged 55 years and over

3.0 Local Defined Outcomes

The Provider has agreed to adhere to the 'Evaluation Framework' for the recording of information and data related to the project performance. Please see Appendix 1 below for full details of framework.

A suitably timed post implementation benefits realisation review needs to be undertaken and the Provider agrees to support this review.

3. Scope

Aims and objectives of service

The aims and objective of the Frailty* (*Staying Well) Services Pilot Project is to deliver a safe and effective Multi-Disciplinary Team (MDT) based service which enables service users to avoid hospital admissions. The overarching aims, and objectives are to;

- Enhance the patient pathway by effectively managing patients within the most appropriate setting
- Provide fast, timely access to assessment, treatment and care
- Prevent avoidable hospital attendance and admission
- Contribute appropriate data to an evaluation framework which will monitor impact of the service

Service Description

It is noted that the Staying Well Pilot will develop and mobilise services which are focused in the South of Staffordshire i.e. Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG and Stafford & Surrounds CCG areas.

Any wider roll out would be expected to take account of the pilot evaluation and deliver the same outcomes using the same evaluation framework for all service users.

The Provider will carry out their responsibilities in relation to Schedule 5 – Governance, Part C - Provider's Material Sub-Contracts, regarding the subcontracting arrangements to deliver the service.

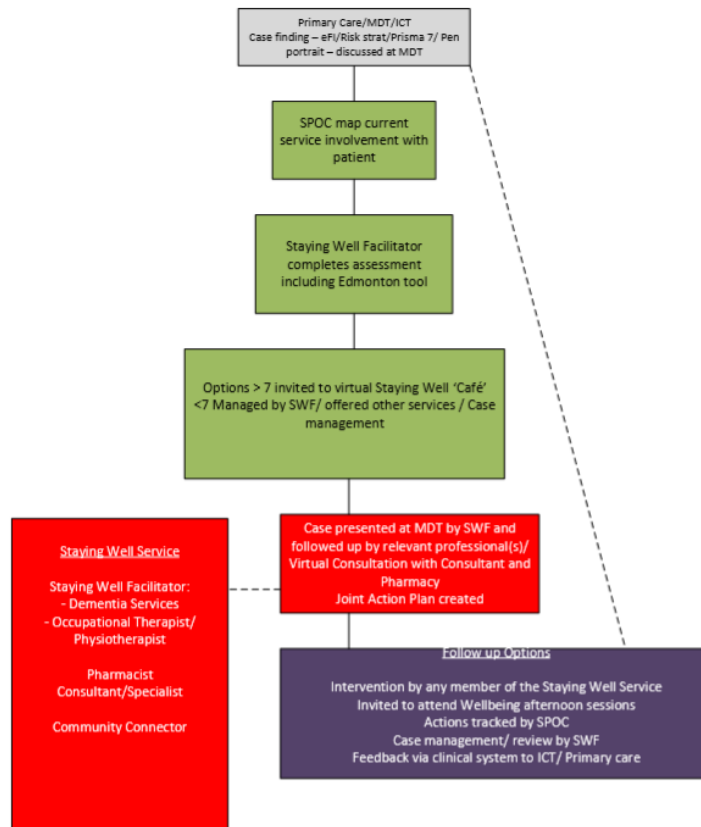
Referral Pathway

Referral to the service is via GP referral (Seisdon patients are identified via MDT meetings of 8 Seisdon Practices).

Care Pathway (Seisdon)

Seisdon Staying Well Model

Key
 Primary Care
 MPFT
 MD Staying Well 'Café'
 Community or ICT



Each respective CCG has agreed to commission the pathway in order to deliver the outcomes above and meet the aims and objectives of the Staying Well Service; the funding will be utilised for System Partners to provide and deliver and **models may vary between CCGs:**

Seisdon Model

- Identification will be facilitated by a Staying Well Facilitator joining existing Practice MDT meetings held in each of the 8 Seisdon practices.
- For assessment the identified primary need of the patient will determine which lead Staying Well Facilitator i.e. Nurse, Dementia Nurse, Occupational Therapist/ Physiotherapist will offer and complete an holistic assessment (if accepted by the patient). **(Community Provider).**
- The Staying Well Facilitator will analyse the results of the assessment and refer on to appropriate professional within Staying Well Service (Nurse, Dementia Nurse, and Occupational Therapist/Physiotherapist) to address any additional needs or refer on to other appropriate services (MPFT, Primary Care, Social Prescribers, voluntary services etc.).
- Where a patient scored 7 and above on the Edmonton frailty scale they will be invited to attend a virtual consultation with a Consultant/Specialist (based on patient need) and Pharmacist, and would be offered access to a Wellbeing Session (e.g. Staying Well Café) **(i.e. virtual information/advice/education sessions/ Q&A sessions/ support groups).**
- Patients may be cohorted to ensure access to specific specialties.

- Care Plan actions tracked by Single Point of Contact and case managed by Staying Well Facilitator **(Community Provider)**
- Any Care Plan actions which require GP input are to be clearly communicated **(Community Provider)** and actioned **(Primary Care)***.
- The Community Provider will operationally manage the Staying Well Service.

Population Covered

- The service shall initially provide care to any patient who is identified as mild-moderately frail (identified using a ratified tool) and that is registered with Cannock Chase NHS CCG, Stafford and Surrounds CCG, South East Staffordshire & Seisdon Peninsula CCG General Practitioner (GP), and is aged 55 or over.
- Identification of frailty is complex but should include electronic Frailty Index (eFI) scoring along with clinical assessment using a validated tool (e.g. Rockwood) and/or based on known clinical history.

Interdependencies with other services

- The Provider will use their specialist expertise to creatively develop safe and effective ways to deliver positive outcomes in collaboration with partners and by building on existing good practice and positive relationships.
- The Provider will support patient access to other relevant services in line with their existing referral criteria as required in accordance with individual needs as below, but not limited to:
 - Allied Health Professions
 - Primary Care/General Practitioners
 - Acute and Community Hospitals
 - Other Community Services E.g. Infection & Prevention Team, Tissue Viability Team, Continence Team, Dietetics Team
 - Exercise Providers
 - Independent sector
 - Voluntary sector
 - Warmer Homes/Beat the Cold Schemes
 - Energy Saving Trust

Workforce

The Service shall be responsible for ensuring that (where relevant) their clinical and / or non-clinical staff are:

- Trained in the agreed Standard Operation Procedures for the service.
- Trained in the use of EMIS (Egerton Medical Information Systems) as the current central information portal for this service

Governance

All Service Providers delivering parts of the pathway will take on full governance responsibility for patients treated. They will ensure that appropriate and adequate medical governance is in place to support the safe and effective delivery of the service.	
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.
4.2	Applicable Standards Set Out in Guidance and/or Issued by a Competent Body (e.g. Royal Colleges) N/A
4.3	Applicable Local Standards Please refer to Schedule 4c
5.	Applicable Quality Requirements and CQUIN Goals
5.1	Applicable Quality Requirements (See Schedule 4A-C)
5.2	Applicable CQUIN Goals (Not Applicable)
6.	Location of Provider Premises
In response to the covid-19 pandemic individual assessments, MDTs and Wellbeing Cafes will routinely be virtual. In order to mitigate inequalities of access, there will be an option for face to face subject to appropriate risk assessment. When it is judged to be safe and appropriate and following risk assessment the Provider may visit people's homes and/or operate out of a range of premises with locations agreed with the Commissioner and for ease of access for the Service Users to a safe environment (cold sites)	
7.	Individual Service User Placement

Not applicable.

*The vast majority of the actions on the patients care plans will be completed by the staying well service MDT, whether that be OT, nurse, dementia nurse etc. or another member of the community service team.

However, there will be occasions where tasking back is required and necessary.

Examples are:

- Recommendation for a change of medication, (unless it's an urgent change that needs to be made) pharmacists will task it back to the GP so they can prescribe preferred brands or arrange for any follow up that might be needed i.e. blood tests, phased reduction in medication that needs to be monitored etc.
- Referral to a specialist/ service is recommended and that service or specialist will only accept a referral from the patients GP'.

Appendix 1 – Pan Provider Evaluation Framework (v 5.1) This framework contains metrics from all parts of the service including primary, secondary, community and voluntary sectors. Data Collection will be automated						
		Description/Notes	Metrics	Source of Data	Frequency	Collection
1.	Demographics					
1.1	Age	Mean/ range		EMIS	Quarterly Report	Primary Care (GP) initiate referral Collated by MPFT from referral information
1.2	Sex	Proportion		EMIS	Quarterly Report	Primary Care (GP) initiate referral Collated by MPFT from referral information
1.3	Ethnicity	Proportion		EMIS	Quarterly Report	Primary Care (GP) initiate referral Collated by MPFT from referral information
1.4	EFi register Score/Prisma 7/ *self-assessment tool (*future development)			EMIS /Primary Care	Quarterly Report	Primary Care (GP) initiate referral Collated by MPFT from referral information
2.	System measures					
2.1	Occupied bed days	Per head of population over 55*	Baseline by HUB to be determined and trajectory agreed	SUS/ SLAM	Monthly as KPI	CCG/CSU/GP
2.2	Delayed Transfer of Care	Per head of population over 55*	Baseline by HUB to be determined and trajectory agreed	SUS/ SLAM	Monthly as KPI	CCG/CSU/GP
2.3	A&E attendances	Per head of population over 55*	Baseline by HUB to be determined and trajectory agreed	SUS/ SLAM	Monthly as KPI	CCG/CSU/GP
2.4	Non-Elective admissions	Per head of population over 55*	Baseline by HUB to be determined and trajectory agreed	SUS/ SLAM	Monthly as KPI	CCG/CSU/GP
2.5	Number of re-admissions within 30 days	Patients over 55 who have been re-admitted within 30 days	Baseline by HUB to be determined and trajectory agreed	SUS/ SLAM	Monthly as KPI	CCG/CSU/GP
2.6	Admissions to long term care * (Future development)					External evaluation metric
3	Case Finding					
3.1	Number of patients referred	Total number identified within primary care.	Actual vs trajectory	Primary care allocated /register totals	Quarterly	GP Referrals data MPFT track referrals against planned activity by area and PCN.

3.2	Referral numbers by practice- eFI classification	Number referred by practice – and Classification of frailty – mild/ moderate/ severe	Numbers Mild by Practice Numbers Moderate by Practice Numbers severe by Practice (inappropriate referral)	Primary care/ EMIS	Quarterly	GP Referrals data MPFT record eFI classification.
	Source of referral*(future development)	All referrals are GP currently and funding follows the GP referral. Option to widen referral routes if required.	Referrals by practice covered by 3.2.			
4 Activity Measures- Staying Well Service						
4.1	Time to assessment - from referral to contact by Single Point of Contact (SPOC).	Mean time and range to contact from referral (Pro-active preventative service – not an urgent service. Expectation of reasonable time between referral and assessment. To monitor and establish 'mean' time).	Service data	Spoc	Monthly	Spoc at MPFT or provider
4.2	Patients known to community Services/ currently in place	Numbers/ proportion already using relevant services prior to referral. Metric is to test the appropriateness of referrals.	Statistically significant sample audit of care plans to be completed.	Spoc	Monthly	Spoc at MPFT or provider
4.3	Number of EICaf assessments	Number of patients seen for EICaf assessment/ proportion of Edmonton scores on index	Service data	Spoc	Monthly	Spoc at MPFT or provider
4.4	Number Referred to Hub pathway /versus referred to other services	Numbers/ proportion referred to HUB. (Conversion rate approx. 40%) Numbers referred to other services. What services/signposts referred to if not suitable for hub.	Service data	Spoc	Monthly	Spoc at MPFT or provider
4.5	Services used at HUB /utilization	Numbers/ proportions of patients using MDT Frailty hub services. Number of patients seeing which type of clinician.	Service data	Spoc	Monthly	Spoc at MPFT or provider
4.6	Onward referrals post Hub	Numbers/ proportions/ type of onward referral from hub.	Service data	Spoc	Monthly	Spoc at MPFT or provider
4.7	Hub staff utilization & Medical reviews /CGAs completed*	% professional utilisation & No of Medical Reviews Geriatrician assessments/Pharmacist reviews completed.				Spoc at MPFT or provider

4.8	% of patients with a care plan	100% of identified patients in receipt of care plan when leave hub	Service data Statistically significant sample audit of care plans to be completed	Provider audit	Monthly	Spoc at MPFT or provider
5	EoL Specific					
5.1	Proactively identify people considered to be in the last year of life at an early stage	Numbers identified	Statistically significant sample audit of care plans to be completed	Provider audit	Monthly as KPI/ audit of care plans quarterly	Spoc at MPFT or provider
	Staff satisfaction					
5.2	Staff satisfaction and learning From all agencies involved	Focus Group (Plan, Do, Study, Act (PDSA Cycle).		Multi-agency Focus Group	Bi-annual	All (Operational Management led)
5.3	Short staff survey From all agencies involved	Survey monkey or equivalent		All Provider survey	Quarterly	All (Operational Management led)
6	Patient experience and reported outcomes (Patient Activation Measures (PAM))					
6.1	Increase number of patients who feel involved in their care plan.	Questionnaire pre and post-assessment (Patient Activation Measure- PAM)	Statistically significant sample audit of pre and post PAM to be completed. Further detail on PAM measures included in Evaluation Report (Benefits Realisation).	Provider audit	Bi-annual	MPFT or provider
7.	Risks and Complaints					
7.1	Complaints	Number of complaints received Each organisation		Provider data/ DATIX	Quarterly	All Org systems via leads As part of MPFT SLAs?
7.2	Incidents	Number of incidents recorded Each organisation		Provider data/ DATIX	Quarterly	All Org systems via leads As part of MPFT SLAs?
7.3	Outcome of incident review	Multi-agency investigation to be completed; outcomes reported Each organisation		Multi-agency group report/ DATIX	Quarterly	All Org systems via leads As part of MPFT SLAs?
7.4	Compliments	Each organisation		Multi-agency group report/ DATIX	Quarterly	All Org systems via leads As part of MPFT SLAs?

Specifications – pending review/development

Ref No.	Service Spec	CCG	Status
Specifications agreed as priority for joint review in 2022-23			
MH_04	Adult Community Mental Health and Social Care Team Service (CMHT)	04Y Cannock Chase 05D East Staffordshire 05Q South East Staffordshire & Seisdon Peninsula 05V Stafford & Surrounds	MPFT Main
MH_05	Early Intervention in Psychosis (EIP)	04Y Cannock Chase 05D East Staffordshire 05Q South East Staffordshire & Seisdon Peninsula 05V Stafford & Surrounds	MPFT Main
MH_11	Crisis Resolution Home Treatment	04Y Cannock Chase 05D East Staffordshire 05Q South East Staffordshire & Seisdon Peninsula 05V Stafford & Surrounds	MPFT Main
MH_16	Perinatal Service – Outpatient/Community	04Y Cannock Chase 05D East Staffordshire 05Q South East Staffordshire & Seisdon Peninsula 05V Stafford & Surrounds	MPFT Main
MH_17	Psychiatric Liaison Service	04Y Cannock Chase 05D East Staffordshire 05Q South East Staffordshire & Seisdon Peninsula 05V Stafford & Surrounds	MPFT Main
MH_19	Children and Adolescent Mental Health Service (CAMHS)	04Y Cannock Chase 05D East Staffordshire 05Q South East Staffordshire & Seisdon Peninsula 05V Stafford & Surrounds	MPFT Main
Included In 2019-20 Contract for development in year			
CS_35	Discharge to Assess (D2A) Community Beds	05G North Staffordshire 05W Stoke-on-Trent	For review
*CS_36 *Superseded by CS_55	~~Homefirst~~	~~05G North Staffordshire 05W Stoke-on-Trent~~	~~For review~~
CS_37	Brighton House – Rehabilitation, Reablement and Assessment Unit	05G North Staffordshire 05W Stoke-on-Trent	For review
CS_41	Rheumatology	05G North Staffordshire 05W Stoke-on-Trent	For review

Ref No.	Service Spec	CCG	Status
	Community Hospitals (replace with step up and step down)	TBC	For review
	Community Intervention Services (Adult) / Intermediate Care / Re-ablement Intermediate Care / UCR 2-hour	TBC	For review
	District Nursing	TBC	For review
	Jackfield	TBC	For review
	Palliative Care Co-ordination Centre	TBC	For review
	Speech and Language (Childrens)	TBC	For review
	Tissue Viability – City and County	TBC	For review
	Blood Transfusions	TBC	For review
	Cancer and Supportive Therapies Team	TBC	For review
	Community Based Support for Individuals with Learning Disability (with/without autism) and forensic needs	TBC	For review
	Physiotherapy (childrens)	TBC	For review

Specs developed – for agreement			
	Youth Participation	TBC	To be agreed
	CYP Crisis Home Treatment	TBC	To be agreed

SPECIFICATIONS – PENDING REVIEW/DEVELOPMENT

Specifications Agreed as priority for joint review in 2022-23

Service Specification No.	MH04	
Service	Adult Community Mental Health and Social Care Team Service (CMHTs)	
Commissioner Lead	Nicky Bromage	
Provider Lead	Lisa Agell	
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		
<u>Policy context</u> • Policy Implementation Guidance CMHT DH 2002 • Refocusing the Care Programme Approach DOH 2008 • No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)		
<u>Local strategic context</u> • Staffordshire and Stoke on Trent Adult Mental Health Strategy ‘Mental Health is everybody’s business’ 2014-2019 • Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 • Up to date statistics can be found on the POPPI and PANSI HSCIC systems.		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
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		
• First contact after receipt of referral is made with the service user within 24 hours (urgent), 3 working days (Non urgent), either face to face or other form of communication to make formal arrangements for an assessment to commence. • Assessments will be completed within 4 weeks from first face to face contact. Assessments will be made from 4 weeks off initial referral date. • All assessments, Treatment / interventions commenced within eighteen weeks of referral. • The need for hospital admissions will be reduced through early detection and providers working with service users and carers to develop effective relapse prevention plans. • Out of area placements repatriated following review • Transition service users to primary care resulting in the reduction of secondary care need. • Reduction of inequalities in health care.		

- Service users have access to accommodation suitable for their needs.
- Service users supported to maximise income.
- Service users are supported to retain and gain paid employment
- Service user's carers and families are well informed.
- A whole family approach is taken when working with service users.
- Service users are seen as partners in care and care plans are co-produced.
- To prevent crisis where possible
- To use of outcome measures, including user defined outcomes, to measure success

3. Scope

3.1 Aims and objectives of service

The team provides an integrated whole systems assessment and treatment service for individuals within the individuals home or a community setting close to home, including nursing and residential homes, that is person-centred and recovery focussed.

The Service objectives are to:

- Provide prompt and expert assessment of needs for people referred to the service.
- Provide effective, evidence-based treatments to reduce and shorten distress and suffering.
- Provide support to CR/HT services to ensure people are supported in the community.
- To provide multi-disciplinary team approach to support the users in the community.
- Ensure that inappropriate or unnecessary treatments are avoided
- Ensure the care is delivered in the least restrictive and disruptive manner possible.
- Assist service users and carers in accessing support, both to reduce distress but also to maximise personal development and fulfilment.
- To provide a comprehensive community Mental Health Service to older people presenting with functional disorders such as depression, bi-polar disorder, psychosis
- Provide advice and support to service users, families and carers.
- Stabilise and improve social functioning and protect community tenure.
- Establish a detailed understanding of all local resources relevant to support of individuals with mental health issues and promote effective interagency working.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this and religious and gender needs.
- Provide support and advice to primary care through collaborative working.
- Reduce the stigma associated with mental health care
- Establish effective liaison with local general practice, IAPT Teams, Acute Care, Early Intervention teams and other internal and external referring agents to establish processes to manage complex cases
- To ensure services users are supported to access appropriate physical health care and healthy lifestyles interventions/advice
- To work in partnership with other providers eg third sector to avoid duplication of provision and maximise the opportunities for 'Recovery' for the individual

3.2 Service description/care pathway

To deliver interventions underpinned by the principles of 'Recovery' and anti-discriminatory Practice whilst promoting Social Inclusion.

Care Pathways – See Documents to be Relied on Schedule 5A

Pathway

Referral ➡ Assessment ➡ Care Plan ➡ Care & Treatment ➡ Review
 ➡ Discharge in accordance with CPA

The service will have the appropriate multi-disciplinary workforce and have the adequate skills mix to provide the relevant interventions and meet the required service objectives and outcomes.

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford and surrounds, Cannock Chase, East Staffordshire, South East Staffordshire, and Seisdon.

3.4 Any acceptance and exclusion criteria and thresholds

CMHT Service user groups covered

- Adults and Older adults (age 16 and above) presenting with moderate to severe and/or enduring mental illness, including Care clusters 4 to 8 and 10 to 17 and with provision for joint working with IAPT services for 'step up and step down'.
- The service also provides assessment and support for carers of the above service users.

CMHT Exclusion criteria

Those whose needs are best met elsewhere include:

- Individuals under the age of 16 years
- Individuals with organic disorders
- Individuals with a primary diagnosis (non-dual diagnosis) of learning disability, substance misuse,
- Individuals presenting with mental health needs at step 2 or below (stepped care model)

Days/ hours of operation

CMHT = Monday –Friday- 9.00 – 1700

(Excluding Bank Holidays)

CMHT Referral processes

Referrals are accepted from any source through a Single Point of Access via phone, fax, post or in person

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, CR &HT, CMHT's. Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. BME communities. Staffordshire and Stoke on Trent Partnership Trust, Social Inclusion and Recovery Services e.g. Life Links, Changes

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

All relevant NICE Guidance complied with.

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

4.3 Applicable local standards

This is not intended as a non-exhaustive list:

- A seamless approach to mental health care in conjunction with other providers and other specialist mental health providers will be delivered.
- A coordinated interface between primary and secondary care delivery will be maintained.
- An integrated approach will be taken to the interface between physical and mental health care.
- A positive coordinated approach to all physical long term conditions care is required. This service will offer emotional and psychological support/interventions where appropriate.
- Consideration should be given to undertaking an assessment regarding safeguarding issues.
- Where necessary specialist advice and support should be sought such as for substance misuse, housing support and criminal justice agencies

5. Applicable quality requirements and CQUIN goals

5.7 Applicable Quality Requirements (See Schedule 4A-C)

5.8 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Stafford & Surrounds CMHT
Foundation House
Stafford ST15 3AG
Tel: 01785 783033

Cannock Chase CMHT
Park House
12 Park Road
Cannock
WS11 1JU0
Tel: 01543 431580

Burton and Uttoxeter CMHT
Horninglow Clinic
Carlton Street
Burton
DE13 0TF
Tel: 01283 538030

Tamworth CMHT
Andrew Ward,
Sir Robert Peel hospital
Plantation Lane
Mile Oak
Tamworth
Staffs B78 3 NG.
Tel: 01827 308820

South Staffs (Seisdon) CMHT
Codsall Lodge
Histons Hill
Wolverhampton
WV8 1AA
Tel: 01785 783030

Burntwood and Lichfield CMHT
St Michael's Hospital
15 Trent Valley Rd
Lichfield
WS13 6EF
Tel: 01543 414555

7. Individual Service User Placement

Service Specification No.	MH05
Service	Early Intervention in Psychosis
Commissioner Lead	Nicky Bromage
Provider Lead	Lisa Agell
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.14 National/local context and evidence base

Policy context

- Refocusing the Care Programme Approach DOH 2008
- No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)
- Mental Health Policy Implementation Guidance <http://www.iris-initiative.org.uk/silo/files/mh-policy-implementation-guide-2003.pdf>
- Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16 <https://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf>

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012
- Up to date statistics can be found on the POPPI and PANSI HSCIC systems

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

Fidelity to the agreed service specification and to the EI evidence base

Improving access, engagement and support

- A reduction in the duration of untreated psychosis to a median of three months and a maximum of six months.
- A reduction in the number of people reaching services via an acute pathway (especially A&E and police)
- The use of involuntary treatments in the first engagement will be less than 25%
- Service users shall receive a Care Plan, Risk Management Plan, Relapse Prevention Plan, and Crisis Intervention Plan that records their individual needs and reflects their participation

and choice/preferences. The documents will focus on the service user's strengths, interests, abilities and capabilities, not on their deficits, weaknesses or problems.

- v. Service Users and their carers/family members will know who their Care Co-ordinator is and how to contact them or their representative should the need arise.
- vi. Primary Health and General Practitioners and families and carers will be active participants in supporting service users, receiving copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans that record their participation and responsibilities.
- vii. Incidents of poly pharmacy will decrease due to the participation of primary health practitioners in Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and reviewing process.
- viii. Robust links between the service and Community Mental Health and Social Care Teams, and Child and Adolescent Mental Health Teams resulting in seamless transitions for service users.
- ix. And that interventions to promote recovery and maximise social functioning and resilience should be provided assertively in the first three years following the onset of psychosis.

Raising community awareness

- i. The number of educational establishments/ community agencies/ primary care settings receiving awareness raising briefings will be increased.
- ii. Training programmes and written guidance for GPs and other key agencies detailing the importance of early detection and how to refer people with potential early psychosis will be designed, delivered and published.

Promoting recovery

A reduction in the number of attempts, and of suicides in people with psychosis

- i. Service users will have employment / education rates similar to their age / gender matched peers
- ii. Service users will report satisfaction with their achievement of goals.
- iii. Service users will report that the symptoms of their mental health issues are reduced.
- iv. Service users will report that they are able to access social networks, meaningful daytime activities, and their local communities.

Family engagement and support

- i. Carers will have the opportunity to engage in assessments investigating their needs and receive support plans that record their individual needs and reflect their participation and choice/preferences. The documents will focus on carer's strengths, interests, abilities and capabilities, not on their deficits, weaknesses or problems.
- ii. Carers support plans will be reviewed in conjunction with the service users care plan to examine what is working and not working from the carers, the service users, and care team's perspective. Where appropriate Primary Health and General Practitioners will be given the opportunity to be active participants in reviews.

Self Care

The aim of the service is to improve the quality of services and clinical outcomes, for young people affected by psychosis. The service aims to assist service users in developing self management techniques which maximise their resilience and reduce their vulnerability to what is a serious mental illness which can be extremely debilitating and have a devastating impact on both the individual affected and their family.

Promotion of self care and service user, and care/family member education

- i. The provider will work with service users in ways that assist them in developing self management techniques which maximise their resilience and reduce their vulnerability.
- ii. Supply resources that promote self management e.g. advance decisions (Making my Wishes Known), Wellness Recovery Action Plans,

- iii. Service users and their carers/family members will be given an explanation of their condition and advice about all management options which will be discussed with service users and their carers/family members

Service users and their family/carers should be provided with the following information as a minimum:

- i. Description of the service, range of interventions provided and what to expect
- ii. Name and contact details of care co-ordinator and other relevant members of the team
- iii. Contact details for out of hours advice and help
- iv. Care Plan, Risk Management Plan, Relapse Prevention Plan, and Crisis Intervention Plan
- v. Comprehensive information about medication
- vi. Discharge Summary including information on how to re-referrer in the event of a relapse
- vii. How to express views on the service.

The provider will provide information on services in widely accessible formats, reflecting the language needs of the local population.

3. Scope

3.1 Aims and objectives of service

To provide a service to all people aged 14 and above and their families where the Individual may be experiencing a first episode of psychosis whilst also embracing diagnostic uncertainty. There should be an emphasis on managing At Risk Mental States (ARMS) and psychotic symptoms/experiences rather than diagnosis. It is expected that people will remain with the service for 3 years.

To allow early identification and preventive interventions to mitigate against poor longer term social, psychological and mental health outcomes for people.

Reduce the length of time young people remain undiagnosed and not receiving appropriate interventions and treatment.

To provide sustained and intensive evidence based interventions and promote recovery, particularly in the early phase of a person's psychosis.

To support an individual's continued personal and social development, particularly in relation to education and employment.

To provide support for families affected by psychosis. (Families' in the wider context includes individuals important to the individual service user)

To work with the expectation that people can recover from psychosis, attain ordinary lives and stay well.

To work within a bio-psycho-social approach that is delivered intensively and sensitively during the three years following a first episode of psychosis and for intervention and treatment to be provided in the least restrictive and stigmatising environments that emphasise choice and promote recovery.

To detect psychosis quickly, intervene early and emphasise the need for social as well as symptomatic recovery.

To provide a service which is young person and family orientated and culture, age and gender sensitive.

To deliver an approach with an emphasis upon developing meaningful and sustained engagement based on an assertive outreach principle – in which failure to engage should not automatically lead to case closure.

Provide a user centered service that delivers a seamless service available for those from age 14 and above which effectively integrates child, adolescent and adult mental health services and older adult services and works in partnership with primary care, education, social services, youth and other services.

To improve professional and lay awareness of the need and benefits of early assessment and intervention of an At Risk Mental State (ARMS) and psychosis, to help reduce the ignorance, fear and stigma associated with psychosis.

Ensure that care is transferred thoughtfully and effectively at the end of an individual's involvement with Early Intervention Services

3.2 Service description/care pathway

The Service shall be provided within the principles defined by Refocusing the Care Programme Approach; Policy and Positive practice Guidance; DOH (March 2008)

The Service Provider shall ensure that they:

- i. Create services which are better understood by, and respond to the holistic needs of the Individual and family members
- ii. Improve pathways into access to care, support and health services for the people who need them.
- iii. Ensure that discussions and decisions about the offer of the level and nature of services provided are made in a manner that is fair and easy for the Individual service user to understand.
- iv. Promote wider involvement of voluntary and community organisations, patients/service users, professionals and other staff in the development and evaluation of services.
- v. Facilitate and maintain the development of a skilled and highly motivated health and social care workforce.
- vi. Make the most effective use of funding available in responding to service users' needs within financial envelope.
- vii. Improve existing performance as measured by national performance targets for all parties.

Staff will work collaboratively with service users and their family members/carers, promoting a good understanding of their lives and life situations, in which illness is only one aspect– all clinical and non-clinical staff must be provided with appropriate accredited training in line with individual competencies, and clinical governance to ensure NICE Care Concordance to enable staff to provide accurate, impartial advice and support to service users and carers.

Services will be accessible by all members of the community, e.g. through appropriate opening times and location and provision of services for vulnerable and socially excluded groups. These might include interpreting/translation services, facilities for disabled people, the homeless, and those in remote or inaccessible areas.

Overview – What can service users and families expect.

This service will provide a responsive and accessible service to people aged 14 and above who appear to be experiencing the symptoms of a first episode of psychosis. This includes those individuals with the early signs of an emerging psychosis (in the prodromal phase), as well as those individuals with frank psychotic symptoms including those individuals with a formal diagnosis of psychosis.

Interventions will be undertaken in collaboration with existing primary and secondary care teams, education providers, employers and employment service providers and other appropriate agencies. It will deliver PIG-compliant and NICE and other evidence based detection and treatments for people suffering from psychosis delivered in a variety of settings close to people's homes so far as it is clinically effective and safe to do.

The provider will be responsible for Individual case management and communicating with the service users' GP when required, including referral to specialist services outside the primary care service, e.g. CMH&SCT, CAMHS, crisis resolution and home treatment etc, as well as appropriate services to ensure the continued social integration of its service users.

There will be a single well-publicised contact point for the referrals to the service to be made and this point to be available for referrers to check out concerns they may have prior to formal referral.

The service should be integrated within the local whole system and have robust communication and interrelationships including clear referral and transition pathways (with universal primary care, specialist and community based services) to prevent hand offs and discontinuities.

Discharge planning from the service will begin at the services first contact with service users.

This initial screening assessment will in most cases be completed within 24 hours and the appropriate clinical documentation completed. It is recognised that in some cases the assessment process may take longer.

If the referral is accepted by the service following the initial assessment the service user will engage in a comprehensive assessment. The comprehensive assessment will include: physical health assessment as routine and psychiatric history; mental state examination; risk assessment – including suicide risk; social functioning and resource assessment; psychological assessment; occupational assessment; family/support assessment; service user's aspirations and understanding; contribution from people important to the service user.

The comprehensive assessment will in most cases be completed within 12 weeks and the appropriate clinical documentation completed. It is recognised that in some exceptional cases the assessment process may take longer and in most cases those individuals will be taken onto caseload as at risk mental states.

Where CMH&SCT's/CAMHS are involved with an individual prior to a referral to the Early Intervention Service, this team should continue to be involved and act as the Care Co-ordinator/Lead Professional until;

- i. The initial assessment has been completed and/or
- ii. A decision reached with regards to the appropriateness of offering ongoing intervention and treatment by the Early Intervention Team and/or
- iii. A Care Co-ordinator/Lead Professional is appointed from the Early Intervention Team.

Team composition

The team will consist of a multidisciplinary team able to deliver full NICE Care Concordance. WTE and banding will be determined by the population size / demography of the local area and Policy Implementation Guide recommendations

Other work:

Health promotion activity

- i. Practitioners will actively encourage and support service users to access Primary Health Care and Health Improvement activities to help reduce physical health care inequalities. This may include providing help to keep appointments etc.
- ii. Ongoing assessment/monitoring will aid the identification of physical health problems which will then be discussed with the GP. If a service user is not registered with a GP or they will not attend their GP the team may take on some limited responsibility where there is clinical competence, and in collaboration with the GP.

Communication

- The provider will ensure that it provides all the information specified by the commissioner and that it communicates effectively and regularly with stakeholders.
- Service users and where appropriate their carer/family members will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.
- All members of care teams supporting service users will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.

The provider will ensure the following is adhered due in regards to communications with GP's:

- Letter sent to GP (preferably electronically) detailing who made the referral and the reasons why and confirming engagement and proposed course of action. GPs would like communication with a plan of care within twenty four hours of assessment.
- At the end of each episode of care, a full letter to be sent consisting of a one page narrative and care plan
- Copy of a Relapse Prevention Plan.

- If the patient has to be admitted then the purpose of admission form should also be sent.

All communication is clear and easy to read after faxing and scanning.

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford and surrounds, Cannock Chase, East Staffordshire, South East Staffordshire, and Seisdon

3.4 Any acceptance and exclusion criteria and thresholds

Accessibility/Acceptability

The Early Intervention Team is a specialist mental health service offering intensive evidence-based interventions to individuals who are:

- Aged between 14 years and above
- Experiencing for the first time symptoms of psychosis
- Where there is a suspicion they may be developing psychosis, not just where there is a certainty
- Who are considered to be at risk of developing psychosis in the future

Diagnostic uncertainty characterises the early phase of a psychosis and thorough clinical assessment is crucial and a key function of an Early Intervention Service, therefore people do not have to have a diagnosis of psychosis to be referred to the team.

Individuals who have previously been in receipt of mental health services or who have previously experienced BLIPS (brief, limited or intermittent psychotic symptoms lasting for less than one week and spontaneously resolving) may also be referred for assessment. However, typically people referred to the Early Intervention Service are likely to be presenting for the first time to mental health services, will not have yet received any antipsychotic treatment or will have been treated for less than one year.

The service will be non-stigmatising and non-discriminatory, providing fair and equitable access.

Day/Hours of operation

The service will be available between 8.00am and 8.00pm seven days per week. Core hours for the teams will be Monday-Friday 9-5 with flexibility to work outside of these hours as necessary

Referral route

Referrals will be received via a single point of access staffed 5 days a week Monday to Friday 8.30 am - 5.00 pm, following which service users will engage in a initial assessment to determine appropriateness of referral. Referrals of people not currently known to specialist mental health services will be prioritised.

The service will also accept referrals from all agencies

Following the assessment service users will either be discharged or supported by specialist mental health services, in the event of support being provided a care plan will be drawn up that clearly identifies needs, interventions designed to meet them, expected outcomes, people responsible for the interventions, and a review date where interventions will be assessed for effectiveness,

Referrals from clinical teams within the provider shall include a copy of the assessment which prompted the referral detailing the outcomes that determined the reason for the referral, and copies of current care, relapse prevention, crisis intervention and risk management plans.

Exclusion criteria

The service shall focus on assisting service users whose mental issues are having a significant impact on their lives. To determine this all service users (and carers/family members) accepted by the service will engage in a comprehensive assessment of their presenting needs.

This list in is not an exclusion criterion, however Teams are less likely to be able to offer support for the following conditions;

- Mild anxiety disorders,

- ii. Primary diagnosis of alcohol or other substance misuse
- iii. Brain damage or other organic disorders including dementia
- iv. Primary diagnosis of Learning Disabilities
- v. Recent history of self-harm but not suffering from a psychotic illness or severe depressive illness
- vi. A crisis related solely to relationship issues

If following the assessment there is ambiguity about the appropriateness of service intervention the service will provide support until the ambiguity is resolved.; the service will operate in dynamic environments with complex presentations of need. The decision to provide support will be based on recorded clinical judgement in response to service users presenting needs.

The service is not usually for people aged less than 14 years old.. Flexibility has been agreed for those individuals just under 14 if we feel we can offer the chance of a better clinical outcome than other potential services

3.5 Interdependence with other services/providers

Key partners can include but will not be limited to:

- i. General Practice
- ii. Trust CAMHS and adult services
- iii. Council Children's services
- iv. Voluntary and community sector
- v. Job centre plus and other employment services
- vi. Education
- vii. Education and training providers
- viii. Substance misuse services

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

All relevant NICE Guidance complied with

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.9 Applicable Quality Requirements (See Schedule 4A-C)

5.10 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Early Intervention Service, First Floor 56 High Street, Burton on Trent, DE14 1JS

7. Individual Service User Placement

Service Specification No.	MH_11
Service	Crisis Resolution and Home Treatment Teams (CRHT) & Acute Day Care
Commissioner Lead	Nicky Bromage
Provider Lead	Lisa Agell
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.15 National/local context and evidence base

- National Service Framework for Older People DH 2001
- Mental Health Crisis Care Concordat (Feb 2014)
- Refocusing the Care Programme Approach DOH 2008
- No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)
- Mental Health Policy Implementation Guidance <http://www.iris-initiative.org.uk/silo/files/mh-policy-implementation-guide-2003.pdf>

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012
- Up to date statistics can be found on the POPPI and PANSI HSCIC systems

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

Better service retention: service users prefer non-inpatient solutions to their mental health crises and this is reflected in higher rates of service retention in crisis resolution services than standard hospital treatment

Reduced admissions and bed use: home-based crisis resolution services can reduce hospital admissions

Reduced duration of admissions: where admission to hospital does occur, the intervention of a crisis resolution service can reduce length of stay

Service users will be supported and encouraged to engage in a comprehensive assessment, including areas associated with risk, of their presenting circumstances and will receive a considered response from specialist mental health services that promotes personal choice, self-management and resilience.

Service users will receive a Care Plan, Risk Management Plan, Relapse Prevention Plan, and Crisis Intervention Plan that records their individual needs and reflects their participation and choice/preferences. The documents will focus on the service user's strengths, interests, abilities and capabilities, not on their deficits, weaknesses or problems.

Service Users and their carers/family members will be informed of who their Care Co-ordinator is and how to contact them or their representative should the need arise.

Primary Health and General Practitioners, carers and families, will be active participants in supporting service users and the service will ensure that Primary Health and General Practitioners receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans that clearly records their participation and responsibilities.

Incidents of poly pharmacy will decrease due to the participation of primary health practitioners in Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and reviewing process.

Service users will be supported and encouraged to actively engage with services and the incidents of unplanned/self-discharge will decrease.

Service users will have the opportunity and be supported by the service to maintain social contacts and relationships, whilst receiving intensive support.

Robust links between the service and Community Mental Health and Social Care Teams will be in place resulting in seamless transitions for service users.

Psychiatric hospital admissions will be reduced as individuals are supported via more flexible options which meet their needs enabling them to maintain relationships and social contacts.

Service users, cares/family members, and care team members will be informed of changes in service interventions and transitions across provider services. For example the discharge from an in-patient resource will be co-ordinated and Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans will be disseminated to care team members prior to the event taking place.

Admissions to psychiatric hospital following requests for assessments under the Mental Health Act should decrease as the service will provide a less restrictive resource for Approved Mental Health Professionals co-ordinating assessments.

The aim of the service is to improve the quality of services and clinical outcomes, reduce psychiatric hospital admissions, reduce length of stay in psychiatric hospital and assist service users in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis.

Promotion of self-care and service user, and care/family member education

- The provider will work with service users in ways that assist them in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis.
- Supply resources that promote self-management e.g. advance decisions (Making my Wishes Known), Wellness Recovery Action Plans,
- Service users and their carers/family members will be given an explanation of their condition and advice about all management options which will be discussed with service users and their carers/family members

Service users and their family/carers should be provided with the following information as a minimum:

- Description of the service, range of interventions provided and what to expect
- Name and contact details of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice and help
- Care Plan, Risk Management Plan, Relapse Prevention Plan, and Crisis Intervention Plan
- Comprehensive information about medication
- Discharge Summary including information on how to re-referrer in the event of a relapse
- How to express views on the service.

3. Scope

3.1 Aims and objectives of service

The purpose of this specification is to set out the requirements for a Crisis Resolution and Home Treatment Service and Acute Day Care for the population of South Staffordshire.

The service will provide an alternative to psychiatric hospital based treatment for appropriate service users experiencing mental health difficulties who are either in crisis or severe distress that are referred to specialist mental health services. Service users will be referred to hospital only when there is a clearly identified clinical need for psychiatric hospital based specialist services – with inclusive reference to those individuals assessed under the Mental Health Act (including section 136) as well as those assessed within informal situations.

The aim of the crisis resolution and home treatment service and acute day care is to improve the quality of services and clinical outcomes, reduce psychiatric hospital admissions and assist service users in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis. Provision of intensive support in home treatment through integrated 'acute day care' function. Ability to deploy workers with clinical skills to work intensively with individuals in 'safe spaces' as an alternative to hospital admissions and Monitoring of care plans and interventions from clinically trained staff.

The service will also provide supports to service users (and their carers/family members) who have been admitted to a psychiatric hospital by assisting them in developing self-management techniques which

maximise their resilience and reduce their vulnerability to crisis, enabling early discharge from psychiatric hospital and reducing the length of time they require in-patient support.

The service shall respond to referrals promptly, minimising presenting risk and alleviating stress faced by service users and others, such as carers as appropriate.

The multi-disciplinary service will provide a crisis response to individuals in the community experiencing and presenting in crisis with debilitating mental health difficulties and – for those individuals assessed as requiring an alternative to psychiatric hospital admission as a resolution to that crisis – the service will provide intensive support to that individual in their own homes or in other accommodation. The Home Treatment service will stay involved until the need for the intensive intervention is ended and the service user continues with an ongoing care package provided by another service typically this would be resolved within a period of 6-8 weeks to maximise the efficiency of the service.

The service will provide prompt and effective home treatment, including ongoing assessment and review, medication management and psycho-social interventions in order to prevent imminent psychiatric hospital admissions. People will be supported in the least restrictive environment possible with the minimum of disruption to their lives. The service is offered as an alternative to psychiatric inpatient care.

The service will support people in their community, ensuring the preservation of family networks and support and enabling service users to access local social networks. The service will also give support and advice to informal carers.

The service will gate keep all admissions. From the point of any necessary admission to psychiatric hospital, the home treatment service will be involved with all appropriate discharge planning with intensive support being provided to enable early discharge from psychiatric hospital to be achieved.

The service will practice in a framework that promotes personal recovery, assisting service users to develop self-management techniques which reduce their vulnerability to crisis and maximise their resilience.

The service will provide high quality, evidence-based interventions which represent good value and is responsive to local needs and national guidance and policy.

3.2 Service description/care pathway

The Service shall be provided within the principles defined by Refocusing the Care Programme Approach; *Policy and Positive practice Guidance*; DOH (March 2008)

Practitioners will be skilled and welcoming. Staff will be guests in peoples' homes (or other domicile which may include temporary accommodation). Practitioners will promote a good understanding of the service users' lives and life situations, with a focus on recovery and - with regards to their overall life situations - will promote an understanding that illness is only one aspect. All clinical and non-clinical staff will be provided with appropriate accredited training in line with individual competencies, and clinical governance to enable staff to provide accurate, impartial advice and support to service users and carers.

Services will be accessible by all members of the community, e.g. through appropriate opening times and location and provision of services for vulnerable and socially excluded groups. These might include interpreting/translation services, facilities for disabled people, the homeless, and those in remote or inaccessible areas.

The service provides short-term crisis intervention and, where appropriate, crisis resolution to assist adults aged 16 or above with no upper age limit, who are undergoing a crisis where mental illness appears to be a dominant factor or with a severe mental illness (e.g. schizophrenia, bi-polar disorders, severe depressive disorder) who are experiencing a life situational crisis that is affecting their ability to function normally and has overwhelmed their usual coping mechanisms.

The service provides support to adults aged 16 or above with no upper age limit, experiencing an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, psychiatric hospitalisation would be necessary

Where there is a risk of admission to psychiatric hospital the service will assist service users to remain at home during a period of ill health. The service will provide intensive care and treatment at home (or other appropriate domicile), including where necessary daily visits and assistance with medication.

If a psychiatric inpatient admission is necessary, the service will facilitate early discharge by early involvement in discharge planning, and consulting with inpatient multi-disciplinary teams, service users and carers. Staff will attend inpatient multi-disciplinary meetings to facilitate early discharge.

Discharge planning from the service will begin at the first contact with service users and should involve resources/personnel who will work with service users after discharge.

Service model

The service shall comprise a multi-disciplinary, specialist discreet team with a breadth of skills to ensure that it can;

- respond appropriately to referrals,
- engage service users in comprehensive assessments,
- respond appropriately to identified needs,
- allocate staff members to co-ordinate service users care,
- provide intensive support, including home visits, to support service users through episodes of crisis,
- deliver, administer, and monitor medication,
- assist service users with daily living issues e.g. housing, caring responsibilities, benefits,
- assist carers/family members by providing information and practical support,
- deliver interventions which promote the development of self-management techniques enabling service users and their carers/families to maximise their resilience reducing their vulnerability to crisis,
- assist service users in compiling plans that identify relapse indicators and define what to do in the event of a crisis.
- ensure that plans are shared with primary care, G.P. and others as appropriate,
- develop links to a range of respite options,
- if required facilitate transitions to psychiatric in-patient resources that enable service users to access lowest stigma/least restrictive environments,
- facilitate transfer or discharge of care to the most appropriate resource, ensuring that support options are available to service users and information relating to care episodes is communicated to relevant parties,
- actively involve service user and carer/family throughout the period of engagement, from referral through to discharge.

Staffing

Staff who will oversee the assessment and support of service users referred to this service shall:

- Hold a recognised medical, nursing, social work, occupational therapy, or psychology qualification with a level of skill and knowledge appropriate for the assessment and subsequent engagement with service users and their carers/family members,
- In addition, the provider will employ additional staff to provide relevant support to service user's and carers/family members under the appropriate clinical, professional and management supervision of one or more of the above,
- The service must have 24-hour access to senior psychiatrists to carry out assessments in locations outside of hospital settings.

Communication

- The provider will ensure that it provides all the information specified by the commissioner and that it communicates effectively and regularly with stakeholders.
- Service users and where appropriate their carer/family members will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.
- All members of care teams supporting service users will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.

Days/Hours of operation

The service will operate 7 days a week, 24 hours a day,

The team (as described above) will be available 24 hours a day to undertake home visits to service users who are known to specialist mental health services.

Care Pathways – See Documents to be Relied on Schedule 5A

3.3 Population covered

The service shall cover the operational boundaries of all the South Staffordshire CCG's including Stafford & Surrounds, Cannock Chase, East Staffs, South East Staffs and Seisdon.

3.4 Any acceptance and exclusion criteria and thresholds

Accessibility/acceptability

Referral criteria & sources

The service shall respond to requests for the assessment of adults aged 16 years or above (with no upper age limit, who are undergoing a crisis where mental illness appears to be a dominant factor. The service user must be aware of and agree to the referral to CRHT and must be able to give informed consent to receiving the service once referred (where capacity to make that decision exists).

The service shall respond to direct crisis referrals via Single Point of Access from primary care, community mental health and social care teams, Approved Mental Health Professionals, staff on inpatient wards, the criminal justice system, non-statutory agencies, former service users and their family/carers, Accident + Emergency departments and other parts of the acute medical service.

Referral route

Referrals will be received in-hours via SPA and out-of-hours via CRHT providing, through both pathways, access 24 hours a day, 7 days a week, following which service users will be supported to engage in a comprehensive assessment of their needs,

Response time & detail and prioritisation

The service user will be contacted within 1 hour of the crisis referral being received by the CRHT team with the aim of establishing face to face contact with the service user wherever possible within 2 hours but certainly no later than 4 hours after time of referral to CRHT unless an alternative timescale is agreed with the referrer. If this is not achieved reasons why will be communicated to the referrer and an agreed plan will be documented.

Service users will be discharged from the service when the outcomes detailed on their care plan which relate to the service have been achieved.

Discharges will only occur following a review of service interventions and presenting circumstances, outcomes will be communicated to all agencies that have a role in interventions including General Practitioners.

If the service user requires to be supported by specialist mental health (for example by the Community Mental Health Team) following the intervention outcomes where CRHT had a role in those being achieved, the Care Co-ordination responsibility, if the home treatment service provided this function, will be allocated to an alternative, suitably qualified named individual. CRHT staff will work collaboratively with other professionals/teams to support take up by CPN or consultant as an outpatient in a timely fashion (target for CMHT response is 4 weeks)

Exclusion criteria

The service shall focus on assisting service users whose mental health issues are having such a significant impact on their lives that they could potentially be admitted to hospital. To determine this all service users (and carers/family members) referred to the service will engage in a comprehensive assessment of their presenting needs.

If the assessment does not identify the acceptance criteria outlined then this service is not usually appropriate and teams are less likely to be able to offer intensive support for the following conditions;

- Mild anxiety disorders,
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia
- Primary diagnosis of Learning Disabilities
- Recent history of self-harm but not suffering from a psychotic illness or severe depressive illness
- A crisis related solely to relationship issues

If following the assessment there is ambiguity about the appropriateness of service intervention, the service will provide support during the episode of crisis. The list above is not an exclusion criterion; the service will operate in dynamic environments with complex presentations of need. The decision to provide support will be based on recorded clinical judgement in response to service users presenting needs. If a referral is inappropriate then this should be documented and communicated to the referrer and/or the GP detailing why this decision has been reached and suggesting alternative pathways that might be followed.

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. BME communities. Emergency Duty Service, Staffordshire & Stoke on Trent Partnership Trust.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

All relevant NICE Guidance complied with

5. Applicable quality requirements and CQUIN goals

5.11 Applicable Quality Requirements (See Schedule 4A-C)

5.12 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Service Specification No.	MH_16
Service	Perinatal Service – Outpatient/Community
Commissioner Lead	Nicola Bromage
Provider Lead	Wendy Hallows, Midlands Partnership NHS Foundation Trust
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.6 National/local context and evidence base

Policy context

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

- No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)
- Royal College of Psychiatrists Perinatal Maternal Mental Health Services April 2000
- Department of Health (2003): Mainstreaming Gender and Women's Mental Health: Implementation Guidance. London: Department of Health.
- Department of Health (2002): Women's Mental Health: into the mainstream. Strategic Development of Mental Health Care for Women. London: Department of Health

Joint Commissioning Panel for Mental Health (2012) *Guidance for commissioners of perinatal mental health services*. http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf.

Maternal Mental Health Alliance (2014) *UK specialist community perinatal mental health teams*. <http://everyonesbusiness.org.uk/wp-content/uploads/2014/07/UK-Specialist-Community-Perinatal-Mental-Health-Teams-current-provision.pdf>

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012
- Up to date statistics can be found on the POPPI and PANSI HSCIC systems.

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

- Service users report that they have received both emotional and physical support and feel more confident as parents.
- Service users who have been followed up show a reduced score for anxiety and show a reduced score for depression. GAD7 or PHQ9.

service users are seen to have developed good communication and a close bond with their baby,

3. Scope

3.1 Aims and objectives of service

The service provides assessment, treatment and care for women suffering from mental health problems associated with pregnancy and childbirth including, puerperal psychosis, severe depression, anxiety related to childbirth, relapse of existing mental illness and attachment disorder.

They aim to provide the optimum improvement in mental health for the woman, so the patient is able to function as a carer for her infant whilst maintaining her own safety and that of the infant.

3.2 Service description/care pathway

Service Description

The service provides assessment, treatment and care for women suffering from mental health problems associated with pregnancy and childbirth including severe post-natal depression and puerperal psychosis.

Assessment

Comprehensive assessment includes a detailed account of the patient's history, their current mental health, details of children allergies medical history and history of prescribed medication, family history social and personal history past obstetric history and current pregnancy and clients expectations of treatment and motherhood. A full risk assessment is also undertaken.

Care planning

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

Treatment and Care

The Perinatal Team offers early intervention and appropriate level of specialist treatment and care for women suffering from psychiatric disorder associated with pregnancy and childbirth. The team assesses women both antenatally and postnatally.

The service will see women who are not currently ill but who are at risk of developing a mental illness due to a previous mental illness episode especially postnatally, or due to family history.

New referrals can be accepted up to the 11th postnatal month. Women can be seen and treated for the first postnatal year.

The Team will accept referrals for women who are considering conception and have an enduring mental health problem requiring advice regarding specialist medication and treatment.

The team can advise other professionals on the management and treatment of women during pregnancy or the postnatal period and co-work with other Community Mental Health Teams.

Treatment options include:

- Full comprehensive assessment
- Risk assessment and relapse monitoring/planning
- Individual therapy
- Medication monitoring in pregnancy and in breast feeding
- Baby massage
- Anxiety management
- Support for carers
- Education for patient and their families on perinatal illnesses
- Relapse management

Skill mix

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

Training/ Education/ Research activities

To aspire to continuously meet standards and work towards accreditation with relevant professional bodies.

Care Pathways – See Documents to be Relied on Schedule 5A

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford, Cannock Chase, East Staffs, South East Staffordshire and Seisdon

3.4 Any acceptance and exclusion criteria and thresholds

The team provides a service for adult female patients who are aged 16 years plus.

Exclusion criteria

People whose only need is:

- Substance misuse
- Personality disorder
- Miscarriage
- Stillbirth
- Termination
- Existing anxiety disorder
- Mild to moderate depression
- Relationship problems
- Social problems
- Housing problems
- Child protection issues where there are no mental health problems

Days/ hours of operation

The service is predominantly a 9am-5pm service; there is flexibility outside of these hours if required.

Referral processes

The service accepts referrals from General Practitioners, Obstetricians, Consultant Psychiatrists and Community Mental Health Nurses. Referrals from Midwives, Health Visitors and Social Workers are accepted with the agreement of the General Practitioner.

This is a tertiary care service and therefore we do not accept community crisis referrals.

A decision will then be made as to both the appropriateness of the referral and, if accepted, the degree of urgency. An assessment is then conducted by one of the senior clinicians.

Referral Criteria

Preconception

Preconception counselling for women with existing severe and enduring mental health difficulties and for those who have had a previous puerperal psychosis.

Antenatal

- Women in the antenatal period who are experiencing a moderate to severe depression.
- Family history of Bipolar illness
- Past or present severe mental illness
- Schizophrenia
- Previous puerperal psychosis
- Previous treatment by a Psychiatrist/Specialist Mental Health Team including inpatient care
- Severe depression
- Pathological Anxiety related to childbirth
- Family history of perinatal mental illness

Postnatal (up to twelve months)

- Severe depression following childbirth
- Puerperal psychosis or manic episode
- Severe anxiety related to childbirth/infant
- Attachment disorder
- Women with existing severe mental health difficulties where professionals need to co-work with local Community Mental Health Team
- Child protection issues only where there are significant mental health problems

Response times

The service works towards the 18 week referral to treatment framework.

Discharge process

In general, discharge will be a process agreed by all parties; the patient, nurse, carer and other professionals.

The service will work with women whose infant is up to the age of 1 year. After this, the patient's care will be transferred to the care of their local Community Mental Health Team if deemed appropriate. Otherwise they will be discharged back to the care of their General Practitioner.

3.5 Interdependence with other services/providers

NHSE commission inpatient facilities. If the person has been an inpatient the first 3 months of activity are funded through NHSE.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All relevant NICE Guidance complied with

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

- Royal College of Psychiatrists Perinatal Maternal Mental Health Services April 2000
- Service is aspiring to achieve accredited by the Royal College of Psychiatrists

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.7 Applicable Quality Requirements (See Schedule 4A-D)

5.8 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises are located at:

The Perinatal Service is based at, St George's Hospital, Corporation Street, Stafford, ST16 3AG (Tel: 01785 221554).

Clinics are available throughout South Staffordshire.

7. Individual Service User Placement

Service Specification No.	MH_17
Service	Psychiatric Liaison Service
Commissioner Lead	Nicky Bromage
Provider Lead	Lisa Agell
Period	1 st April 2022 to 31 st March 2023
Date of Review	By 31 st March 2023

1. Population Needs

1.7 National/local context and evidence base

Policy context

- National Service Framework Mental Health DH 1999
- National Service Framework Older People DH 2001
- Managing Urgent Mental Health Needs in Acute Hospitals, Academy of Medical Royal Colleges, 2008
- NICE Guidance on Self Harm
- HM Government (2011). No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London: Department of Health.
- Aitken, P. (2007). Mental health policy implementation guide: liaison psychiatry and psychological medicine in the general hospital. London: Royal College of Psychiatrists
- NHS Confederation (2009). Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation.
- Closing the Gap: Priorities for Essential Change in Mental Health (Feb 2014)
- Mental Health Crisis Care Concordat (Feb 2014)
- The NHS Belongs to the people: A call to action

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012

People aged 65 and over predicted to have severe depression, by age, projected to 2030					
	2014	2015	2020	2025	2030
People aged 65-69	56,400	56,700	50,900	53,600	61,800
People aged 70-74	43,200	45,200	53,600	48,400	51,200
People aged 75-79	32,800	33,800	40,900	49,000	44,600
People aged 80-84	22,800	23,300	28,100	34,500	41,900
People aged 85-89	13,500	14,000	16,900	21,000	26,400
People aged 90 and over	7,700	8,100	10,500	14,000	18,900
Total population 65 and over	176,400	181,100	200,900	220,500	244,800
Figures may not sum due to rounding. Crown copyright 2014					

People aged 65 and over predicted to have depression, by age and gender, projected to 2030					
	2014	2015	2020	2025	2030
People aged 65-69 predicted to have depression	4,735	4,763	4,278	4,506	5,191

People aged 70-74 predicted to have depression	3,558	3,722	4,419	3,990	4,229
People aged 75-79 predicted to have depression	2,781	2,858	3,445	4,129	3,759
People aged 80-84 predicted to have depression	2,146	2,194	2,639	3,254	3,942
People aged 85 and over predicted to have depression	1,916	1,997	2,429	3,057	3,923
Total population aged 65 and over predicted to have depression	15,136	15,534	17,210	18,936	21,044
Figures may not sum due to rounding. Crown copyright 2014					

People aged 18-64 predicted to have a mental health problem, by gender, projected to 2030					
	2014	2015	2020	2025	2030
People aged 18-64 predicted to have a common mental disorder	82,304	82,129	81,300	80,356	78,887
People aged 18-64 predicted to have a borderline personality disorder	2,299	2,294	2,270	2,243	2,201
People aged 18-64 predicted to have an antisocial personality disorder	1,799	1,797	1,783	1,766	1,740
People aged 18-64 predicted to have psychotic disorder	2,045	2,040	2,019	1,996	1,959
People aged 18-64 predicted to have two or more psychiatric disorders	36,848	36,774	36,418	36,011	35,379
Figures may not sum due to rounding. Crown copyright 2014					

Self-harm admissions

Nationally self-harm is one of the top five causes of acute medical admission and those who self harm have a one in six chance of repeat attendance at A&E within the year. During 2010/11 there were over 1,500 admissions due to self-harm in Staffordshire with overall rates being similar to the national average. However self-harm admission rates in Cannock Chase, East Staffordshire and Stafford are higher than the England average.

Self harm is often an expression of personal distress and there is a significant and persistent risk of future suicide following an episode of self harm

Although suicide rates have fallen nationally, in recent years they did show an upward trend in the south, where between 2006 and 2009 the number of suicides and undetermined injuries doubled from 36 to 73. The 2010 data shows that the numbers have fallen in the south (35 suicides and injuries undetermined). Suicide rates for men are over treble those for women.

National Context

- mental disorder accounts for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions
- self-harm accounts for between 150,000 and 170,000 A&E attendances per year in England
- MUS may account for up to 50% of acute hospital outpatient activity
- 13–20% of all hospital admissions and up to 30% of hospital admissions via A&E at weekends are related to alcohol
- in England, alcohol-related hospital admissions doubled in the 11 years up to 2007, and alcohol-related deaths also doubled in the 15 years to 2006
- one quarter of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital.

- most patients who frequently re-attend A&E departments do so because of an untreated mental health problem
- two thirds of NHS beds are occupied by older people, up to 60% of whom have or will develop a mental disorder during their admission.

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

The quality outcomes of liaison services include:

- improved service user experience and care outcomes
- improved access to mental health care for a population with high morbidity
- reduced emergency department waiting times for people with mental illness
- reduced admissions, re-admissions and lengths of stay
- reduced use of acute beds by patients with dementia in Burton General Hospitals Trust (Mid Staffs General Hospital Trust commission a dementia service separately).
- reduced risk of adverse events
- enhanced knowledge and skills of acute hospital clinicians
- improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)
- improved compliance with NHS Litigation Authority Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST).

3. Scope

3.1 Aims and objectives of service

The general remit of the Liaison Psychiatry Service is, and the

- All those involved in providing the service shall acknowledge and respect service user and carer's gender, sexual orientation, age, race, religion, culture, lifestyle and values. The service will be non-discriminatory and anti-oppressive by way of service delivery and Equality Impact Assessments will be completed as appropriate.
- The Service will be provided within the principles defined by Refocusing the Care Programme Approach; *Policy and Positive practice Guidance*; DOH (March 2008) which are:
 - The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, and goals and aspirations as well as their needs and difficulties. It recognises the individual first and patient/service user second.
 - Care assessment and planning views a person in 'the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical well-being.

- Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate equitable and co-ordinated care. The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.
- Care planning is underpinned by long term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.
- to offer full psychosocial assessment
- provide time limited interventions
- develop aftercare packages based on individual need for service users aged 16 and over who have a mental health concern and are in-patient. Including the A&E department.

Objectives:

- Support service users by building on their strengths, maintaining their levels of independence and promoting well-being
- Provide prompt and expert holistic mental health assessment of people presenting in A&E departments referred by the department to the service
- Provide effective, evidence-based treatments to reduce and shorten distress and suffering.
- Ensure that inappropriate or unnecessary treatments are avoided
- Ensure the care is delivered in the least restrictive and disruptive manner possible.
- Assist service users and carers in accessing support, both to reduce distress but also to maximise personal development and fulfilment.
- Provide advice and support to service users, families and carers.
- Establish an understanding of local resources relevant to support of individuals with mental health issues and promote effective interagency working.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Reduce the stigma associated with mental health care

Establish effective liaison with local Community Mental Health and Social Care, Crisis Resolution and Home Treatment, Assertive Outreach, and Early Intervention teams to establish processes to signpost appropriate cases.

3.2 Service description/care pathway

Service description/ care package- overview ie what is provided

Dependant on the review of the current model and performance of the Liaison Psychiatry Service as highlighted in the current Service Development Plan which forms part of the South Staffs Commissioning Intentions, this section (and others within the document) is subject to change. Any proposed changes need to be agreed between the Commissioners and the Provider.

Key component	Key Elements	Comments
<u>ASSESSMENT</u> – Working in	• Initial screening and discussion to ensure service is appropriate for the patient	

collaboration with Medical Team	• Full psychosocial assessment • If appropriate, make referral to other services and ensure adequate continuity of care • Physical health assessment where appropriate • If appropriate, multi-disciplinary assessment of service user's needs and level of risk • Assessment should actively involve the service user, carer / family and all relevant others e.g. GP • Substance Misuse • Older Person Mental Health Issues • Risk Assessment • Medication Management	
1.1.1 PLANNING Working in collaboration with Medical Team	• Produce a focused care plan • Begin discharge planning at an early stage • After care plans • Follow – up with relevant services	• Team approach and team decision making • Active involvement of the service user • Include input from family / carers • Care Plan must be flexible enough to respond rapidly to changes in the clinical situation
1.1.2 INTERVENTION Team Approach	• Responsible for co-ordinating the service user's care in collaboration with medical team • Provides continuity of care and ensures effective communication within the team	• Service user and family / carers involved in
On-going support	• Frequent contact throughout in-patient stay for new referrals AND service users already known to mental services • Ongoing risk and needs assessment • Service must have the capacity to follow service user throughout in-patient stay	

Medication	• Care designed to improve concordance (co-operation with treatment) • Service user involved in decision making and monitoring effects of medication • Side effect monitoring to be done regularly by service user and staff • Advice to General Hospital staff regarding use of psychotropic medication	• Staff need training in medication management • Links with hospital and local pharmacies required to ensure evidence based practice • Careful attention to avoiding / reducing side effects vital if engagement and concordance are to be maintained
Family / carer support	• Ongoing explanation to family / carers • Education about the service user's illness • Arrange practical help as needed	• Involvement of carers / family and provision of support during in-patient stay are key components of recovery
Co-ordinate Care/Linking services	• Ensure high level of communication and smooth transition between services whether statutory or non statutory • Liaise with other services to ensure continuity of care	
Interventions aimed at increasing resilience	• Range of therapies for both service user and family / carers should be available including: -Problem solving -Motivational interviewing -Stress Management -Brief supportive counselling • Interventions aimed at maintaining and improving social networks	
Crisis management	• Hospital staff to have understanding of when to call for help • Out of hours for in-service users, on-call Consultant Psychiatrists are available • Out of hours for A&E Crisis Resolution Team are available	• Easy access to help 24 hours a day
1.1.3 DISHCHARGE Plan/Links with others	• Discharge planning should begin early • Information about the mental health issue, interventions and ongoing care should be exchanged with relevant others (GP, CMHT)	• Prior to discharge the team should ensure that: ○ There is a good understanding (service users, family, carers, relevant others) of why the mental health issue has

	- Discharge possibilities will be dependant on clinical situation and local service provision but could include transfer of care to: - Primary Care - Assertive Outreach Team - Early Intervention Team - Continuing Care - Other Mental Health Services - Non statutory agencies	occurred and how it could be avoided in future - Coping strategies have been explored with the service user and family / carers - Service user / family / carers have had the opportunity to express their views about the service and contribute to service improvement

Close links with statutory and non statutory agencies are essential for Liaison Psychiatry so that:

- Handover and referrals are made easily
- Crises are anticipated and contingency plans are known to all involved in care
- Staff from the Crisis Resolution Team and Liaison Psychiatry Teams are clear about the close working practices shared between the teams

Discharge process

Once psychological assessment and plan of care is identified there is liaison with A and E Multi disciplinary team to ensure that service user is medically fit and an appropriate pathway is then initiated

Skill mix

The team will be skilled and welcoming and will have a good understanding of clients needs and will have a range of skills and the appropriate accredited training

STAFFING

Key skills - High energy level - Team Player - Ability to creatively engage service users - Understanding of needs of service users, including specific needs related to cultural background / age / gender etc - Able to co-ordinate and provide broad range of interventions	- CNS/Team Leader - Liaison Mental Health Nurses - Sessional Consultant Psychiatrist
Medical Staff - SHO's active members of the team via clinical placement 24 hour access to senior psychiatrists via on-call system-St. Georges (ext 5000)	Involvement from both sessional Consultant Psychiatrist and Junior Doctor
Administrative and Clerical	Admin support

Training/ Education/ Research activities

The team will comply with the Trust's mandatory training programme and all staff will have appraisals at which training needs are identified

All staff will have the opportunity to take part in appropriate research and audit activity

Training opportunities provided by the Liaison team include:

- Understanding self-harm
- Working with people who self-harm
- Older people's needs
- Mental capacity
- SHO induction (Acute and Psychiatric)

Training provided to the liaison staff includes:

- Vulnerable adult training
- Child Protection training
- Equality and Diversity training
- Nurse Prescribing
- Medication Management
- Motivational Interviewing
- Values and Psychosocial Intervention
- AMSPAR(admin training)
- Certificate in Mental Health
- Values and Psychosocial Intervention
- AMHP course
- Physical Health in Mental Health Care
- Nurse Prescribing
- Psychosocial Intervention
- Leadership Role in Quality, Innovation & change
- Occupational Therapy Training
- Infection Control training
- Health and Safety training
- Lifting and Handling
- First Aid
- Carer support training
- Family Therapy
- Customer service training
- Dual diagnosis training
- Mental Health Act
- Fire Safety training
- Mappa
- SUI training
- Complaints training
- Learning Lessons event

3.3 Population covered

Service users attending County Hospital Stafford, Queens Hospital Burton, Robert Peel Tamworth, and Samuel Johnson Lichfield.

3.4 Any acceptance and exclusion criteria and thresholds

Service user groups covered (including care clusters, where relevant)

- Adults (16 years to end of life)
- Covering the whole range of Mental Health Issues
- In-service users (including A & E)

Exclusion criteria

This service is not usually appropriate for individuals without mental health difficulties and who suffer with:

- Primarily Learning Disabilities
- Uncomplicated bereavement issues
- Relationship issues
- Housing & Benefit issues
- Violent tendencies

However all referrals will be discussed at the time of referral

Days/ hours of operation

County Hospital:

Monday to Friday, 9:00 – 17:00 excluding Bank Holidays

Out of hours operation via crisis resolution and home treatment teams and duty psychiatrist (through Access Service)

Queen's Hospital Burton (including community hospitals):

Monday to Saturday 8:30 – 16:30 excluding Bank Holidays

Out of hours operation via crisis resolution and home treatment teams and duty psychiatrist (through Access Service)

Referral processes

- Telephone access (pager)
- Written referral accepted to team base

Response times

Emergency: an acute disturbance of mental state and/or behaviour which poses a significant, **imminent** risk to the patient or others. **These service users should be seen within 60 minutes.**

Urgent: a disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement. Or, service users who are judged medically fit for discharge from an acute hospital but require a mental health assessment before leaving. **These service users should be seen within one working day.**

Routine: all other referrals, including service users who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge. **These service users should be seen within two working days.**

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. BME communities.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

This is not intended to be an exhaustive list

NICE (2009). *Depression with a chronic physical health problem: the treatment and management of depression in adults with chronic physical health problems* (partial update of CG23). Clinical guidance 91. London: NICE.

Anxiety: <http://guidance.nice.org.uk/CG22/Guidance/pdf/English>

Dementia: <http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf>

Depression: <http://www.nice.org.uk/nicemedia/pdf/CG23fullguideline.pdf>

Drug misuse: <http://guidance.nice.org.uk/CG51/NiceGuidance/pdf/English>

Schizophrenia: <http://www.nice.org.uk/nicemedia/pdf/CG82FullGuideline.pdf>

Self-harm: <http://guidance.nice.org.uk/CG16/Guidance/pdf/English>

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

Aitken, P. (2007). *Mental health policy implementation guide: liaison psychiatry and psychological medicine in the general hospital*. London: Royal College of Psychiatrists

Quality Standards for Liaison Psychiatry Services. Royal College of Psychiatrists 2011.

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.9 Applicable Quality Requirements (See Schedule 4A-C)

5.10 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

County Hospital , Stafford

Queen's Hospital, Burton

7. Individual Service User Placement

Service Specification No.	MH_19	
Service	Child and Adolescent Mental Health Services	
Commissioner Lead	Nicola Bromage	
Provider Lead	David Pike	
Period	1 st April 2022 to 31 st March 2023	
Date of Review	By 31 st March 2023	
1. Population Needs		
All current and future legislation and guidance in relation to the delivery of child and adolescent mental health services and services children and young people. The service is expected to comply with all local safeguarding policies and respond to any recommendations from Serious Case Reviews, learning reviews and independent Reviews The service will adopt relevant NICE guidance as it is issued. The service will adopt agreed pathways of care as they are developed in partnership with the service and partners.		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
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		
Staffordshire's' Emotional Wellbeing and Mental Health Strategy (2014-2018) outcomes:		
Domain 1	Children and Young People develop emotional resilience which enhances their emotional wellbeing and mental health	X
Domain 2	Reduction of demand for specialist services	X
	More children and young people maintain good emotional wellbeing and mental health	X
Domain 3	Children and Young People who become emotionally and mentally unwell are supported to manage their conditions and recover quickly	X
	Children and young people recover without recourse to medication	X

Domain 4	Increase in seriously ill children and young people who can be cared for in their community	X	
Domain 5	Vulnerable groups of children and young people are able to access support quickly, and therefore manage their conditions enabling quick recovery	X	
Domain 6	Commissioners will have better information about need and prevalence of emotional wellbeing and mental health issues within the 18-25 age groups; in order to commission effective, evidence-based solution	X	

3. Scope

3.1 Aims and objectives of service

Aim

Improve and enhance the emotional wellbeing and mental health of children and young people who are experiencing emotional and mental distress.

Provide high quality, comprehensive, multi-disciplinary and multi-modal specialist child mental health provision to the children and families of South Staffordshire and support transition to adult services.

3.2 Service description/care pathway

The Child and Adolescent Mental Health Services (CAMHS) is a community based specialist mental health provision. The service provides direct assessment and a range of interventions with children and young people and their families (individual, family or group format); indirect consultation to professionals, families and/or carers; training programmes on relevant child mental health issues; consultative supervision by arrangement; and other activities including audit and evaluation, research, specialist projects and service development.

Community CAMHS Services (South Staffordshire)

The Service will:

- Provide assessment, advice, consultation and treatment for children/young people with severe, complex or persistent mental health disorders (see Appendix A for referral criteria)
- Offer multi-disciplinary services that include psychological therapists including (Child Psychology, Family Therapy, Child Psychotherapy), Allied Health Professionals (Occupational Therapy, Art Therapy), Specialist Nurses, Medical staff, effective operational leadership and administrative support, social workers (employed by Local Authority), youth workers and support workers.
- Provide direct clinical assessment of child and young people admitted to acute settings in South Staffordshire due to deliberate self-harm (provision will extend to children from South Staffordshire admitted to Royal Stoke Hospital and New Cross Hospital – when CV agreed).
- Provide daily screening of referrals to the service, this will include screening referrals to assess priority / urgency in accordance with the CAMHS criteria. Referrals that do not meet the referral criteria will be rejected and discussed with referrer for appropriate redirection. The provider will work with both public and third sector providers to explore and develop agreed care pathways that ensure the most expedient and effective care to children, young people and families.
- Accept referrals for children and young people aged 0-18 where there is a reasonable description that suggests that the child/young person may have an emotional wellbeing or mental health problem in accordance with referral criteria.
- Provide comprehensive assessment of child or young person's mental health, outcome of assessments will be shared with other services involved in the care of the service user with the informed consent of the young person and/or parent/carer.
- Ensure assessment and care planning views a child/young person holistically and within the context of their wider systems including: family; socialising/relationships; wider leisure;

education/employment; housing; creativity; spirituality; self-management with the aim of optimising emotional wellbeing, mental and physical health.

- Work in a collaborative and transparent manner with parents/carers and multi-agency partners whom also may be (or may be required) to become involved within the care of any individual child or young person (this will include active involvement in Early Help Assessment, Team Around the Child, CPA)
- Ensure assessments are undertaken with due regard to obtaining appropriate and informed consents, confidentiality and child protection policies.
- According with best Child Protection practice, ensure each child/young person is given the opportunity to be seen individually as part of the assessment, should this not be possible, clear reasons for this must be recorded within the child/young person's notes
- Ensure every child/young person who receives continuing care from the service has a care plan. A written care plan will be drawn up by the key worker and will incorporate the views of the child/young person and will involve their parents/ carers and wider family members where appropriate. All care plans must include risk management and crisis planning, where appropriate. Care plans should be regularly reviewed, where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.
- Ensure outcomes of assessment and care planning are conveyed in writing to referrer, GP (if different) and copied to service users (as per Trust policy). It may be copied to other agencies with consent of the child/young person and their parent/carer, taking into account requirements of child protection policies.
- Provide intervention/treatment options that are age-appropriate, in accordance with evidence-based treatment / NICE guidance. Treatment may include pharmacological and psychosocial interventions, environmental and occupational/educational interventions or provision. Interventions may also take the form of consultation to other professionals and input into multiagency planning meetings
- Any planning for children and young people with severe educational needs should take account and be part of the child or young person's Education Health and Care plan.
- Put protocols in place to ensure that transitions between services are robust and that, wherever possible, services work together with the service user and parents/carers to plan in advance for transition (this is especially critical in the transfer from CAMHS to adult mental health services and primary care or other services, e.g. voluntary/third sector). As a minimum, children/young people leaving CAMHS should have; a written and agreed care plan detailing what service they will receive post-CAMHS, at least one face-to-face meeting with a named CAMHS key worker and the key worker from the service to which they will move for further care, follow up after the transition, within six months, to ensure appropriate interventions are in place, a written and agreed plan (if no further interventions or treatment are planned) so that the young person and, where appropriate, parents/carer knows what to do if they become unwell
- Use Care Programme Approach is used when young people are discharged from in-patient care or over the age of 16 years and on transition from child and adolescent to adult services
- Ensure that discharge plans are completed with active engagement from child/young person, parent/carer and multi-agency partners. Discharge letters to be sent to General Practitioner, referrer and parent/carer and young person where appropriate

The service will also provide the following additional specialist service provision:

That Place (East Staffordshire only)

That Place provides a tier 2 service for 14-19 year olds; it offers assessment, 1-1 interventions and drop in events across Burton, Tamworth and Lichfield. Its focus is emotional wellbeing and offers predominantly a 6-8 session model. It has robust links with CAMHS and third sector agencies: LSTs, YESS, Paediatrics and Dove.

Provide services to Children and Young People experiencing mild to moderate emotional wellbeing and mental health problems. The service will work with children young people and parents/carers either in clinics and/or community settings such as GP practices, schools or, where appropriate, the home environment.

Children and young people will typically present with one or more of the following; family issues –having an adverse effect and the child or young person is showing signs of developing a mental health problem or

disorder mild to moderate emotional and behavioural disorders, anxiety, depression, stress and or other mood disorders, e.g. low self-esteem, adjustment reactions, simple phobias, self-harm – where this is mild to moderate, bereavement, bullying, anger management issues, relationship problems.

CAMHS Early Years (Cannock and Stafford only) – see Appendix B

The CAMHS Early Years' Service is a pre-school service and aims to support young children before they become of age to start full-time school (i.e. prior to them being eligible to start school Reception year).

The service sees children with complex, persistent and/or severe emotional or behavioural difficulties, usually where interventions have already been attempted in primary or social care services. This might include presenting problems of attachment, trauma, concern over attention, and significant challenging behaviour and social dysfunction.

Additionally, the service will support other professionals in their work with young children and to offer training and consultation, as required.

Paediatric Psychology (Cannock and Stafford only) – see Appendix C

The Paediatric Psychology service is a specialist team offering a range of evidence-based, client-centred interventions to children, young people and families experiencing psychological distress in the context of a physical health problem or disability.

The services will provide:

- Assessment, formulation and therapeutic intervention at the level of the child or family dependent on what is indicated.
- Group based therapeutic interventions where indicated
- Neuropsychological assessment screening for functioning difficulties in situations such as acquired brain injury etc.
- Consultation to medical professionals across a range of disciplines including Paediatricians, Specialist nurses and ward staff
- Diabetes education workshops promoting psychological wellbeing around issues such as adjustment to diagnosis, transition to secondary school and coping with curiosity
- Teaching/training around psychological aspects of different physical health conditions
- Participation in research/audit projects as indicated

Primary Care Mental Health Services (Seisdon only)

Provides consultation and training to professionals working at a Tier 1 level. The service will provide direct clinical interventions when required, and provide a liaison role between community services and Tier 3 CAMHS.

Lead for Participation (South Staffordshire)

Lead on activities in relation to the engagement, involvement and participation of children, young people and their families/carers in service development, including provision of a participation worker on behalf of the CYP IAPT partnership. NB: The participation worker may be sub-contracted from other providers as part of the CAMHS partnership for CYP IAPT.

Leadership for Improving Access for Psychological Therapies (CYP IAPT) (South Staffordshire)

Lead the development and implementation of work streams related to the CYP IAPT programme (in conjunction with other CAMHS partners). Specific responsibilities will include:

- Developing and implementing care pathways, ensuring delivery of evidence based therapies in accordance with CYP IAPT programme
- Implementing the use of routine outcome measures to inform individual care planning and review in addition to overall service evaluation and improvement

- Improving access to psychological therapies, developing pathways and systems that support self-referral and timely access to services.
- Increasing children and young people's participation in service delivery and development (see lead for participation above)

3.3 Population covered Geographic coverage/boundaries

The Service will be available to children and young people up to the age of 18 years who are registered with a South Staffordshire GP and/or live within South Staffordshire.

NB Young People aged between 16 and 18 years will be managed through either CAMHS or adult services, as appropriate and accepted to age appropriateness and individual need, however all young people of this age will be offered a service.

Days/Hours of operation

The Service will operate flexibly within normal working hours (9-5pm Monday to Friday) for the majority of its services.

Community CAMHS Services will operate out of services. Out of hours services will support acute hospital staff and relevant community professionals in providing for the mental health assessment and needs of children/young people in their care out of hours, this includes referrals from police for Section 136 assessments where there is a clearly demonstrated urgent mental health need only.

Out of hours services will operate from 5pm until 10pm on Weekday and 9am – 5pm on Weekends and Bank Holidays Outside of the hours the Adult Crisis Resolution Team will provide telephone consultation and advice for under 16s and take referrals for assessment and treatment of over 16s in accordance with Crisis Resolution referral criteria.

Priority Referrals

CAMHS will prioritise referrals as follows:

- Emergency/Acute* referrals/cases to be seen **same/next** working day
- Next working day access for those children/young people admitted for self-harm
- For routine referrals **(define)**, carry out initial assessment within **eight (8) weeks** of receipt of accepted referral.
- Offer to provide the agreed intervention within **eighteen (18) weeks** of the initial assessment.

*Definition of an emergency and urgent need – Children and young people presenting as emergencies or as requiring urgent assessment and intervention include those who have rapidly developed a serious or life-threatening condition, for example a young person who is psychotic or suicidal; those whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support. This includes children/young people who may be detained under a section 136 who have a clear mental health problem

Referral route

Referrals to all functions within Community CAMHS will be accepted by the following:

Referrals to Community CAMHS Accepted from:	Referrals only accepted from the following after consultation with Tier 3 CAMHS team:
• General Practitioners • Acute Paediatrics • Health Visitors • School Nurses • Child Development Centre staff • Adult Mental Health Service staff • Social Workers	• Head teachers * • SENCO's * • School Counsellors * • Dieticians Speech and Language Therapists • Educational Psychologists *

- Education Welfare Officers
- Behavioural Support Service staff
- CAMHS Primary Care/Early Intervention Service
- Schools
- Self-referral

**referrals will be accepted by Early Years, Tier 2, Primary Mental Health Service without consultation*

3.4 Any acceptance and exclusion criteria and thresholds

Referral Criteria

Referral criteria for Community CAMHS, CAMHS Early Years, Paediatric Psychology and That Place are included as appendices.

Exclusion Criteria

Children and young people may not be eligible for the service provided by SSSSFT on the basis of:

- Being aged 19 and above *
- The referred problem may be best treated in an alternative service (for example, alternative commissioned Tier 2 service, social care team)
- Children in court proceedings where intervention is not advised under Home Office guidelines
- Court assessments, unless specifically contracted
- Where the service is not commissioned including for the following clinical presentations:
 - **Psychological Service for Young Offenders** - the current Provider of this service is Midlands Psychology. Where a presentation/referral/assessment indicates that offending behaviour is occurring and is not as a result of a possible mental health condition, AND the young person has a Youth Offending Worker, the referrer should be signposted/referral should be made to Midlands Psychology.
 - **Autistic Spectrum Disorder (ASD) Service** - the current Provider of this service is Midlands Psychology. Where a presentation/referral/assessment indicates that the presenting concern is ASD the referrer must be signposted/a referral must be made to Midlands Psychology.

When a mental health condition is suspected alongside offending behaviour and ASD, from either the referral to SSSFT or to Midlands Psychology both Providers must follow the joint working protocol agreed for these cases.

For Children/Young People who are placed in South Staffordshire from another CCG area – responsible commissioner guidance will be followed and funding sought from host CCG.

3.5 Interdependence with other services/providers

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Response time & detail and prioritization

The Service will meet the following response times:

- Emergency/acute* referrals/cases to be seen **same/next** working day
- Next working day access for those children/young people admitted for self-harm
- 18 week referral to treatment pathway will apply to all other referrals.

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

4.3	Applicable local standards
5.	Applicable quality requirements and CQUIN goals
	5.2 Applicable CQUIN goals (See Schedule 4E)
6.	Location of Provider Premises
	The Provider's Premises are located at: 4.2 Location(s) of Service Delivery Services to be available in community settings and must be accessible for clients with disabilities and/or parents/carers of young children. Practitioners will work in a variety of settings, including in-reach e.g. into acute provision, Children's Centres, Schools, Pupil Referral Units, residential care settings and family homes.
7.	Individual Service User Placement

Appendix A.

Community Child and Adolescent Mental Health Services (CAMHS)

Referral Criteria (Tier 3)

Population covered

All children and young people who are resident and/or registered with a South Staffordshire GP (who is a member of one of the 4 CCGs operating across South Staffordshire) up to their 18th birthday (young people of 16 or 17 years will be managed by either CAMHS or AMHS dependent upon referral route and/or as clinically appropriate).

If a person is residing temporarily within South Staffordshire area, but are registered with a GP elsewhere (i.e., student or child placed in the area by another authority) discussion will need take place in relation to who is best placed to meet the needs of an individual and a shared care agreement will need to be negotiated by the provider involving the person's originating area's service. Responsible Commissioner guidance will be followed and it is expected that the responsible commissioner for out of area referrals accepted will be re-charged

Acceptance criteria

Referrals from any professionals that work with children and young people will be accepted by the CAMHS Teams where commissioners are satisfied that this is appropriate and where these professionals understand the referral process and what constitutes an appropriate referral. Referrals that do not meet the referral criteria will be rejected and discussed with referrer for appropriate redirection. The provider will work with both public and third sector providers to explore and develop agreed care pathways that ensure the most expedient and effective care to children, young people and families.

All referrals to be made by letter, fax (following security and confidentiality policies and followed up with written referral) or through Common Assessment Framework process. Emergency referrals can be made by phone; however these should be followed up by written referral as above.

Referrals to all functions within Community CAMHS will be accepted by the following:

Referrals to Community CAMHS Accepted from:	Referrals only accepted from the following after consultation with Tier 3 CAMHS team:
• General Practitioners • Acute Paediatrics • Health Visitors • School Nurses • Child Development Centre staff • Adult Mental Health Service staff • Social Workers • Education Welfare Officers • Behavioural Support Service staff • CAMHS Primary Care/Early Intervention Service • Schools • Self-referral	• Head teachers * • SENCO's * • School Counsellors * • Dieticians Speech and Language Therapists • Educational Psychologists * <i>*referrals will be accepted by Early Years, Tier 2, Primary Mental Health Service without consultation</i>

All referrals are to Community CAMHS multidisciplinary/multi-agency team and not to individual clinicians.

Referrers will be required to provide adequate information:

- Name of child/young person (including any alias)
- Ethnicity
- NHS Number
- Name of parent/carer (including who has parental responsibility)
- Current address and phone numbers
- Date of birth of child/young person
- Family composition
- School details
- Overview of current difficulties, including risk factors, duration and impacts
- Overview of interventions to date and outcomes (when/whom/outcomes)
- Any significant family history
- Contact details of other agencies involved with child/young person/family including reason for engagement
- Indication of what help is being requested

Children and young people will present to this part of the service with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. These will include acute presentations.

Children and young people will typically present with one or more of the following (but not limited to)

- Emotional and behavioural disorders (moderate to severe)
- Conduct disorder and oppositional defiant disorder
- Hyperkinetic disorders
- Psychosis
- Obsessive-compulsive disorder

- Eating disorders
- Self-harm
- Suicidal ideation
- Dual diagnosis – including comorbid drug and alcohol use
- Neuropsychiatric conditions
- Attachment disorders
- Post-traumatic stress disorders
- Development disorders
- Significant mental health problems where there is comorbidity with mild/moderate learning disabilities or comorbid physical and mental health problems
- Mood disorders
- Somatising disorders
- NB: Presentations that could be described as emerging personality disorder could be accepted under mood disorder, suicidal ideation and self-harm.

Exclusions

Children and young people may not be eligible for the service provided by SSSSFT on the basis of:

- Being aged 19 and above *
- The referred problem may be best treated in an alternative service (for example, alternative commissioned Tier 2 service, social care team)
- Children in court proceedings where intervention is not advised under Home Office guidelines
- Court assessments, unless specifically contracted
- Where the service is not commissioned including for the following clinical presentations:
 - Psychological Service for Young Offenders - the current Provider of this service is Midlands Psychology. Where a presentation/referral/assessment indicates that offending behaviour is occurring and is not as a result of a possible mental health condition, AND the young person has a Youth Offending Worker, the referrer should be signposted/referral should be made to Midlands Psychology.
 - Autistic Spectrum Disorder (ASD) Service - the current Provider of this service is Midlands Psychology. Where a presentation/referral/assessment indicates that the presenting concern is ASD the referrer must be signposted/a referral must be made to Midlands Psychology.

When a mental health condition is suspected alongside offending behaviour and ASD, from either the referral to SSSFT or to Midlands Psychology both Providers must follow the joint working protocol agreed for these cases.

* Young people age 16-18 years will be managed through either CAMHS or AMHS, as appropriate and receptive to age appropriateness and individual need

APPENDIX B - CAMHS Early Years Referral Criteria

CAMHS EARLY YEARS SERVICE	
GUIDANCE FOR REFERRERS	
Service boundaries	Cannock Chase CCG and Stafford & Surrounds CCG areas
Age of children seen	We see children between 0 and 4 years old. The Camhs Early Years' Service is a pre-school service and aims to support young children before they become of age to start full-time school (i.e. prior to them being eligible to start school Reception year).
Who can refer?	Requests for involvement are accepted from any professional working in children's health or social care services. We also accept self-referrals where the presenting problem/s meets our referral criteria.
Who is the service for?	We see children with complex, persistent and/or severe emotional or behavioural difficulties, usually where interventions have already been attempted in primary or social care services. This might include presenting problems of attachment, trauma, concern over attention, and significant challenging behaviour and social dysfunction.
What don't we do?	We do not provide assessments of, or specific interventions for, parenting capacity, custody & access issues, developmental delay or disorders such as Autistic Spectrum Disorder, or see children where their behaviour is normal for their context. We do not see children who could be managed effectively within universal primary care services or social care services.
Where do we work?	We see children at our clinics at The Bridge in Stafford and at The Grove in Cannock as well as in patient's own homes and nursery settings.
Where to send referrals:	Camhs Early Years' Service, The Bridge, St George's Parkway, Off Crooked Bridge Road, Stafford, ST16 3NE Or contact us on 01785 221 665 to discuss your concerns.

It is not feasible to provide a fully comprehensive guide to suitable referrals, but we hope the information given below is a useful reference tool. However, we also want to stress that we welcome you getting in touch to discuss children you are concerned with, either to offer consultation or to discuss the usefulness of a potential referral.

Problem	Brief Description	Referral Pathway	Additional sources of support, advice, information
Anxiety / Phobias	Some fears are quite normal and developmentally appropriate.	Information about normal range of behaviour.	
	Mild: some difficulty in a single area but generally functioning pretty well. Consistent minor difficulties, mood changes of brief duration, fears & anxieties that do not lead to gross avoidance behaviour.	Health Visitor advice. If more severe, then Local Support Team (LST) or Barnado's	
	Moderate/Severe: if affecting child's development or level of functioning/dramatic deterioration and/or out of proportion to family situation and impacting on parent /carer/child relationship.	Refer to Camhs Early Years.	
Attachment	Mild: such as separation anxiety when starting nursery, adjustment to parental separation/divorce	Health Visitor advice Barnado's	
	Moderate/Severe: where there are significant difficulties for the child arising from the disruption or lack of normal attachments to a primary care giver resulting from parental mental health problems, care issues, or bonding difficulties, or when parenting stress is very high.	Refer to Camhs Early Years May also consider referral to Sustain+ for 'Looked After' child	
Autistic Spectrum Disorder (ASD)	Where you are concerned there are difficulties associated with the 'Triad of Impairment' (i.e. difficulties with social interaction, communication and imagination) or where there are specific difficulties arising directly from an already diagnosed ASD.	Midlands Psychology is the provider of assessment, diagnostic and intervention services for Autistic Spectrum Disorders. Referrals for assessment of a potential ASD from SSSFT to Midlands Psychology should ensure a paediatric opinion has been sought.	
Bereavement	Normal grief reaction. Grief is the normal response to the loss of a loved one and does not necessitate referral to specialist services.	Health Visitor Primary care support Psycho-education	http://winstonswish.org.uk www.cruse.org.uk
	Prolonged normal grief responses	Possible support from 3 rd sector, LST, or Barnado's	
	Child is experiencing significant distress following a death. This might include bereavement as a result of traumatic circumstances e.g. suicide	Refer to CAMHS Early Years	

Problem	Brief Description	Referral Pathway	Additional sources of support, advice, information
Behavioural problems	Normal/Mild Refer to normal development	Health Visitor Primary care support	Local Health Visitor Forum http://incredibleyears.com SSSFT behaviour pathway
	Moderate	Increased support from Health Visitor, LST or Barnado's	
	Significant/Chronic/Complex Where behaviour problems are persistent and severe following significant advice and intervention from other professionals (Health Visitors, Social Workers, Voluntary sector), or when such services are unlikely to be effective, or where additional factors are also present e.g. significant attachment need	Refer to CAMHS Early Years	
Family Difficulties	Emotional and behavioural difficulties in relation to family stresses, for example post-separation or divorce.	Parents should be encouraged to resolve problems before referring to CAMHS.	Relate Family Mediation Services https://www.cafcass.gov.uk/ http://www.understandingchildhood.net/posts/divorce-and-separation-helping-children-and-parents-cope/
	Emotional and behavioural difficulties in relation to abusive relationships	If relating to past history then consider referral to NSPCC, Women's Aid. Where there is an enduring impact on child's well-being then refer to Camhs Early Years. If relating to current abuse then make Safeguarding referral to First Response.	
	If difficulties are associated with parental mental illness	Liaise with Adult services who can contact CAMHS for joint working/referral if appropriate. Where parental mental health directly impacts on child's emotional well-being and needs cannot be met elsewhere then consider referral to LST or Camhs Early Years.	
	Legal issues/reports	Do not refer to CAMHS. Refer to a solicitor who should commission these independently.	
	Where there are serious concerns about a child's welfare or safety	Safeguarding referral to First Response	
Feeding Difficulties	Mild: fussy eating but not associated with significant anxiety or distress or problems with weight gain	Health Visitor advice	

Problem	Brief Description	Referral Pathway	Additional sources of support, advice, information
	Moderate: difficulties accepting normal range or quantity of foods causing distress to child/family and impact on weight	Health Visitor advice Referral to dietitian Referral to Speech & Language Therapy for feeding assessment	
	Severe: significant difficulties with feeding causing concern for physical well-being	Referral to paediatrician or specialist centre	
Sleep Difficulties	Mild:	Information about normal sleep and establishing good sleep habits. Health Visitor advice	http://kidssleepdr.com/
	Moderate/Severe: Where sleep problems, in combination with other behaviour difficulties, are persistent and severe following significant advice and intervention from other professionals (Health Visitors, Social Workers, Voluntary sector) AND where the problem significantly affects child's emotional well-being and parenting stress	Refer to Camhs Early Years Support may also be available from Children's Paediatric Services in cases where a child is already known to them.	
Toileting	Initial toilet training advice should be offered at primary care level.	Health Visitor advice	http://www.eric.org.uk/
	Where problems develop beyond what is developmentally appropriate, initial screening and treatment should be undertaken by appropriate medical professional.	GP assessment Refer to paediatrician or specialist clinic or paediatrician.	http://letstalkaboutpoo.eric.org.uk/
	Where toileting issues, in combination with other behaviour difficulties, are persistent and severe following significant advice and intervention from other professionals (Health Visitors, Social Workers, Voluntary sector) AND where the problem impacts significantly on child's emotional well-being or parenting stress	Refer to Camhs Early Years	http://pathways.nice.org.uk/pathways/constipation
Trauma	Single recent incident:	Information on normal responses to trauma. Health Visitor advice	
	Multiple events or significant traumatic experience where symptoms of trauma are not resolving	Refer to Camhs Early Years	
Looked After Children	Where there is concern about placement breakdown and mental health issues are evident	Consider Sustain+	

General Resources:

Local Health Visitor Forums hosted by Camhs Early Years which focus on training and consultation regarding the above areas with reference to information arising from current caseloads.

<http://www.handsonscotland.co.uk/>

This website aims to help you make a difference to children and young people's lives. It gives practical information, tools and activities to respond helpfully to troubling behaviour and to help children and young people to flourish.

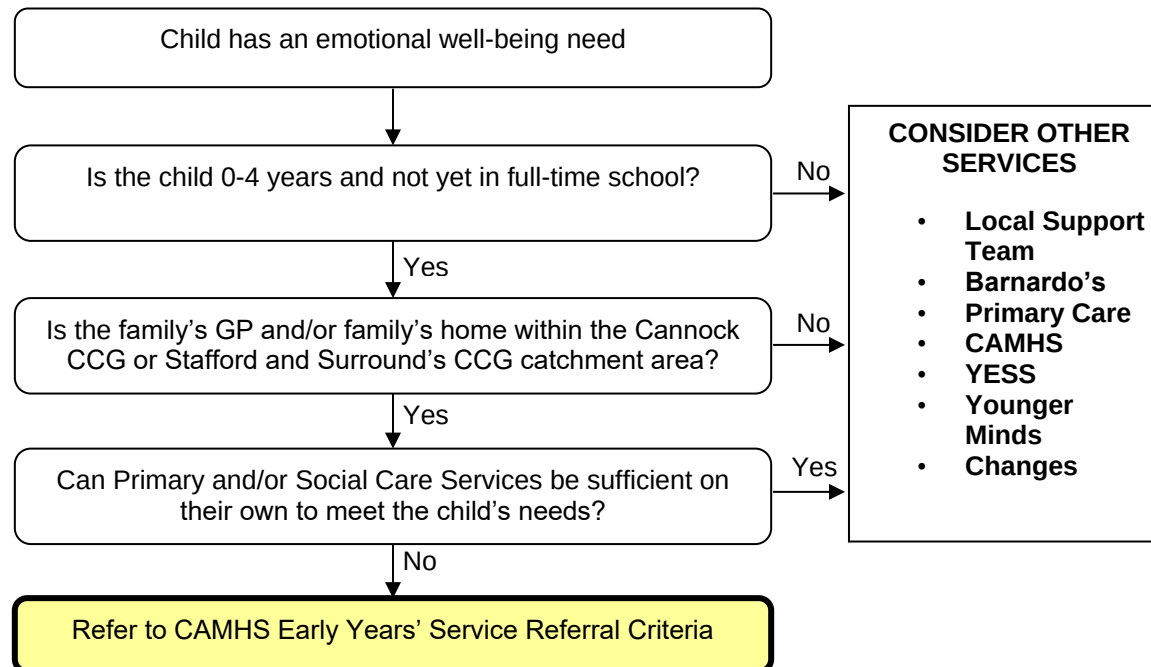
<http://www.familylives.org.uk/>

This web-site provides a range of information for younger and older children. It includes access to an on-line parenting course, parent helpline and on-line chat as well as a range of information leaflets.

<http://www.understandingchildhood.net/>

A range of downloadable leaflets are available for families and professionals with the aim of helping to raise emotionally secure children. Whilst the leaflets cover 0-18years, the primary emphasis is upon early development.

Referral Pathway for CAMHS Early Years' Service



Paediatric Psychology**Referral Criteria****Referral pathways**

Referrals will be accepted from a range of professionals including (but not limited to) Specialist Consultants, Paediatricians, Clinical Nurse Specialists, Ward Staff, GP's, School Nurses and Physiotherapists. The team work on the premise that the quality of the referral is more important than the title of the referrer.

Consent must be given prior to referral by the young person and family and either a referral form completed or letter with equivalent detail written. An indication should also be made as to whether consent has been sought to pass a referral to other agencies if not appropriate for the Paediatric Psychology service, thereby maximising efficiency and reducing waiting times.

Once received, all referrals will be screened for suitability. If accepted into the service, initial 'choice' appointments will be offered within 8 weeks of receiving a referral. From here, clients are either:

- Placed on the routine waiting list for therapeutic input
- Allocated an urgent appointment slot (if clinically indicated)
- Signposted to another, more appropriate service.

Referral types accepted

The team will accept a referral for any child aged 0-18 where there is psychological distress for the individual or family occurring in the context of a physical health problem or disability. This includes but is not limited to:

- Adjustment to chronic health conditions
- Coping with invasive procedures or taking medicines
- Preparing for surgery
- Managing difficult life transitions
- Coping with visible difference
- Pain and chronic fatigue management *
- Complex feeding problems **

*** Chronic pain pathway**

In the event of a referral for chronic fatigue or chronic pain, a pathway exists offering a time limited pain management programme in the first instance. In order for a young person to qualify for this pathway, all medical investigations must first be complete with medical causes ruled out. Prior to referral, the medical team are expected to fully explain the reason for referral to Paediatric Psychology to ensure consent has been received. Following the pain programme, if another type of therapeutic intervention e.g. family work is indicated, this will be discussed with families. There may be a further wait for this service.

**** Complex feeding pathway**

A one off feeding consultation will be offered to children who are living with highly restrictive diets where there is a risk of this impacting on their physical health. This service is available to children school age and above. Referrals should only be made to this service once Dietician and School Nurse input has been tried and any possible medical conditions e.g. swallowing problems have been ruled out. Following consultation, clients may be signposted elsewhere for further input if indicated. In rare circumstances such as weaning off nasogastric feeds or where there is ongoing compromise to physical health, ongoing appointments in Paediatric Psychology may be offered.

Geographic coverage/boundaries

Stafford & Surrounds and Cannock CCG areas

Location(s) of Service Delivery

- Cannock hospital
- County hospital
- The Bridge, Stafford

Specifications Included in 2019-20 Contract for development in year

Service Specification No.	CS_35
Service	Discharge to Assess (D2A) Community Beds
Commissioner Lead	Natalie Cotton, Strategic Senior Manager
Provider Lead	Emma Hall, Interim Community Hospitals Manager
Period	01/04/2019 – 31/03/2020
Date of Review	October 2019
1. Population Needs	
1.8 National/local context and evidence base In order to support urgent care flow through the acute hospital a significant number of patients are discharged from an acute bed into a community setting. This approach has been developed due to a number of factors, some of which are detailed below: • A bed dependency culture in the North of the County where there has been a disproportionate number of community beds, which are too often the default discharge destination. • Patients being assessment within the acute setting at an early stage of their admission when their physical or mental health is not at a point where an accurate assessment can be made. • Too many frail patients being admitted, decompensating and becoming complex discharges requiring high levels of care. • A lack of understanding of the community services available to discharge and the level of care provided. • A demand and capacity mismatch leading to patients being placed in services other than those they have been assessed for, which creates blockages within the system. • Risk adverse decisions that prevent people going straight home when they could do so. The consequence of this approach to discharge is that the system fills capacity rather than meet need, particularly when the system is under pressure which is often the case. This results in significant numbers of patients who are not able to access services promptly, or who are discharged to a bed for assessment or discharge either remaining in the acute trust as medically fit for discharge (MFFD) delay, or being moved into a community bed to wait for the service they actually need. The agreed system wide principle is that we meet need rather than fill capacity. Point prevalence studies, MFFD and Green to Go (G2G) lists and various reviews have indicated what the needs of our population across North Staffordshire and Stoke-on-Trent are. This service is underpinned by the following models of care: • A shift in approach and investment from bed based assessment to discharge to assess, community services and primary care. • Patients will be supported at home through integrated nursing teams, including intermediate care, occupational therapy and reablement service, domiciliary/ home care and enhanced primary care. • Discharge patients 'home first' with discharge to a bed as an exception only when absolutely required. The Services shall be delivered in accordance with the following principles: 1. Respect for capacity: The Patient shall be treated as able to make his/ her own decisions. A Patient's capacity to make a decision will be established at the time that a decision needs to be made in line with the definition of capacity set out in the Mental Capacity Act 2005. 2. Equality of opportunity: The Service shall be organised and provided in a way which does not discriminate against the Patient and Staff in respect of race, gender, disability, sexuality, culture, language, religion or age.	

3. The Provider shall ensure that the Service is at all times delivered in a safe non-discriminatory and non-judgmental manner and that equality and diversity is always promoted.
4. **Individuality:** The Patient shall be recognised and respected as an individual person.
5. **Human Rights:** The Provider shall protect and maintain all entitlements associated with UK citizenship (subject to any authorised “Deprivation of Liberty Safeguards 2008 and Mental Health Act 1983”).
6. **The Human Rights Act 1998** applies not only to public authorities, but also to other organisations when they are carrying out ‘public functions’.
7. Each Provider shall promote and protect Patients’ human rights and act as though it is a ‘public authority’ in relation to human rights obligations.
8. **Choice and Control:** The opportunity to select independently from a range of personalised options; as set out in the NHS White Paper “Equity and excellence: Liberating the NHS” the Government aims to put patients and the public at the heart of the NHS, giving people more control over their health care wherever possible.
9. The divide between health and social care can be confusing to Patients and carers and this document needs to be viewed in line with the Adult Care/ Personalisation Agenda, ensuring that all policies and procedures of Providers and Commissioners and their partner agencies are fully consistent and compliant with national legislation, guidance and best practice.
10. **Independence:** The opportunity to act and think without reference to another person, including willingness to incur an acceptable degree of risk.
11. **Fulfilment:** The realisation of reasonable personal aspirations and abilities in all aspects of daily life.
12. **Privacy:** The right of the Patient to be left alone undisturbed and free from intrusion of public attention into their affairs providing that this does not conflict with any identified Mental Health need.
13. **Dignity:** Recognition of the intrinsic value of the Patient, regardless of circumstances, by recognising their uniqueness and their personal needs and treating them with respect, in line with Department of Health guidance including “Dignity in Care” and “End of Life”, (also relevant Gold Standards Framework/ Liverpool Care Pathway), Dementia awareness.
14. **Confidentiality:** The sharing of any and all kinds of information concerning a Patient shall always be consistent with the principles of consent and data protection as well as choice and privacy.
15. **Protection:** The Patient shall be protected from risk of harm that arises from abuse or neglect;
16. **Patient Engagement:** The Provider shall actively engage with the Patient so that they are consistently contributing – where possible and where considered important by the Patient – to the structuring and delivery of their care.
17. The Provider shall seek family and/ or carer engagement in the care planning process where appropriate including by way of example setting up a carer group.
18. **Person Centred Care:** The Patients’ goals, targets and objectives shall remain the focus of care at all times.
19. **Cultural awareness:** The Provider shall ensure that the religious, cultural and spiritual needs and wishes of the Patient are identified, respected and wherever possible met.

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	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

2.2.1 The Patients’ abilities shall be maximised including cognitive, behavioural, psychological, emotional, mobility and communicative.

2.2.2 The Patients’ health status and safety shall be optimised in regards to:

- Skin integrity

- Concordance with medication
- Continence
- Infection prevention and control
- Nutrition and hydration
- Breathing
- Pain Management
- Mobility including management of the risks of falls
- Impaired cognition

2.2.3 The Patient and/or representative shall feel involved in all aspects of their care planning.

2.2.4 The Patient and/ or representative shall feel empowered to make decisions and choices about all aspects of their life, condition, care and services accessed.

2.2.5 The Patient and/ or representative shall feel they are at all times treated with dignity and respect.

2.2.6 The patient and/ or representative shall feel satisfied with the Services provided and believe that their quality of life is enhanced as a result.

2.2.7 There will be clear standardised pathways of care and discharge arrangements for all Stakeholders including Patients, Carers and Referrers. This will result in improved professional understanding and communication which in turn will reduce duplication of assessments and input, reduce variations in practice, reduce time spent (by both patients and clinicians) in navigating a complex system, and therefore overall improve efficiency, productivity and patient experience.

2.2.8 Emphasis will be placed upon delivery of a service that is timely, leading to best outcomes for patients and/ or representative.

2.2.9 No-one will stay in a bed any longer than required leading to a smooth flow of people moving through services without the development of bottlenecks within the system.

2.2.10 Patients will be placed within the most appropriate service for their needs first time.

2.2.11 Decisions about long term care will be made in an appropriate environment, with more time for engagement with the patient and/or representative.

2.2.12 There will be an increased focus on embedding the principles of 'Home First' that will enable patients to return to their own home to resume more independent lives. Return to home will be the default position for all patients wherever possible.

3. Scope

3.1 Aims and objectives of service

3.1.1 The overall aim and objective of the service is to support patients following an acute episode of physical or mental ill health to be discharged to the setting of least dependency with a comprehensive and sustainable plan of care. This shall also include patients with palliative needs.

3.1.2 During the stay/ placement, patients shall receive further assessment to identify long term needs, continue rehabilitation as necessary and allow arrangements for ongoing care to be put into place.

3.1.3 In addition to the principles set out in 2.2.7, the Provider shall ensure the Service is:

- Responsive at the point of need
- Person centred, based on need
- Outcome orientated
- Evidence based and innovative
- Inter-disciplinary team working across organisational boundaries

Add something about avoidable deconditioning and embracing risk.

3.2 Service description/care pathway

- 3.2.1 Admissions will predominantly be via the Acute Trust (from acute inpatient wards, MFFD wards and emergency portals), however admissions shall be considered from the community e.g. GPs, D2A Care Homes to prevent an A&E attendance and/ or admission.
- 3.2.2 The Services shall work with the Multi-Disciplinary Team (MDT) from the point of admission to implement a multi-disciplinary approach for the delivery of a holistic service for all patients to ensure that patients' needs can be met and assessed co-operatively and promptly.
- 3.2.3 The MDT shall undertake daily reviews to assess patients' needs, goal setting, progress and determine their readiness or otherwise for discharge and/ or transfer to another setting.
- 3.2.4 The Service shall adopt and implement the SAFER Patient Flow Bundle as recommended best practice virtual management system by the Emergency Care Intensive Support Team (ECIST).
- 3.2.5 The Provider shall lead daily/ weekly MDTs to enable a discussion of all cases, share skills, identify risks, share decision-making and shall work together to deliver a joint approach and review the care and support provided. An EDD (expected discharge date) shall be set for all patients **within 24 hours (or next working day)** of admission, and to agree further actions/ interventions if required. The MDT shall include:
- GP/ Lead Medical Cover
 - Therapist (s)
 - Social Worker
 - Ward Manager
 - Other professionals such as Pharmacist, Community Psychiatry Nurse (CPN), Outreach Team and Continuing Healthcare Team (CHC) will be invited as necessary.
- 3.2.6 The MDT shall be responsible for patient reviews and discharge planning. The MDT must seek to ensure that patients do not stay longer than they need to be and that they are discharged back home or to the most appropriate place of residence to meet need in a timely manner.
- 3.2.7 The Service shall focus on minimising delayed discharges from Acute Trusts for patients appropriate for these beds.
- 3.2.8 The Service shall have available resource for accommodating patients undertaking Decision Support Tools (DST) style assessments (if medically appropriate).
- 3.2.9 The Service shall also have available and adequate resource for accommodating the completion of Fast Track Pathway Tools where required.
- 3.2.10 Placements shall be made based on the individual patients' needs and meet the Inclusion Criteria set out in **section 3.4** for:
- General Nursing/ assessment
 - Rehabilitation
 - Stroke Rehabilitation
 - EMI Nursing/ assessment
- 3.2.11 **Roles and Responsibilities of the Provider**
- Pre-Assessment and Admission of Suitable Patients**
- The Integrated Triage and Triage (T&T) Service shall act as the Trusted Assessor on behalf of the Service to ensure prompt assessment of patients.
 - Following receipt of the referral (patients identified as meeting the criteria) via T&T, the Provider shall acknowledge the referral within **2 hours of receipt, 7 days per week** and undertake a clinical handover direct from the referring ward.

- The Provider shall liaise with T&T to facilitate transfer or appropriate patients using the agreed standardised Patient Profile (PP).
- If issues arise with transfer or discharge process, the Provider shall be expected to clearly identify them, work with All Provider Partners to address them and agree improved processes to prevent unnecessary delays from occurring.

Assessment Process

- Lead the assessment process including co-ordination and liaison and involvement of the MDT Team.
- Complete Mental Capacity Assessments (MCAs) as appropriate and ensure Deprivation of Liberty Safeguards (DOLs) application is considered and completed as per guidance (**Mental Capacity Act 2005**) <http://www.legislation.gov.uk/ukpga/2005/9/contents> and **Mental Capacity Act Code of Practice**. http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf Mental Capacity Act Deprivation of Liberty Safeguards (DOLs) and Guidance on DOLs.
- Act as the 'case manager' for all patients.
- Setting of an EDD within **24 hours** of admission
- Participate in a daily/ weekly MDT including goal setting:
 - Provide assertive case management and proactive approach to ensure effective process
 - Proactively review of discharge dates to ensure patient flow
 - Referrals to appropriate medical and diagnostic services as required
- Effective communication and positive relationships between partners
- A safe and timely transfer to the placement location
- The development and finalisation of the comprehensive patient assessment as quickly as possible
- Rehabilitation support and therapy in line with the management plan
- Plan and arrange transfer to the agreed long-term or permanent place of residence, keeping patient and families fully involved
- The Provider shall be fully sighted and adopt the Staffordshire system-wide Choice Policy across these beds. This shall include the use of the policy in supporting choice disputes where required.

GP/ Medical Cover

- Onsite proactive medical cover and off-site telephone support/ advice with a rapid response (**no more than 3 hours**) between core GMS hours Monday to Friday (it is the Providers responsibility to make provision for adequate GP/ medical cover outside of core GMS hours e.g. GP Out of Hours Service, with the responsibilities outlined below:
 - Assessment on admission (**within 24 hours or next working day**) either face to face or by telephone if appropriate;
 - Clinical leadership for weekly MDTs and the MDT team;
 - Participation in the completion of the assessment e.g. DST/ Fast Track;
 - Full medical and prescribing responsibility for all patients in these beds;
 - Medical assessment/ review, management plans, risk management, clinical decision-making, full clinical governance, prescribing;
 - Individual patient discharge summaries.

Physiotherapy and Occupational Therapy

- The Provider shall make available adequate space and equipment as described below and will be available for use when required by the Therapy Team.
- Occupational therapy area, including the following equipment shall be supplied by the Provider: Worktop for food preparation, microwave, kettle, cutlery, crockery, tray, kitchen trolley, table and chairs, fridge.
- Therapy will be provided **7 days per week**.
- The Therapy Team shall provide:

- A range of rehabilitation shall be provided with varying levels of intensity. Patients shall be proactively managed throughout the placement to regain confidence, regain/ maintain mobility and promote independence.
- Re-assessment and update the therapy management plan as necessary on at least a weekly basis and to address any issues or barriers to recovery.
- An assessment of the patients within **24 hours (or next working day)** of their admission to a bed.
- Implement the agreed therapy management plan, which shall include any potential risks.
- Review and monitoring in order to maintain and/ or improve general function status as far as possible.
- Prompt commencement of active physiotherapy and occupational therapy as soon as appropriate.
- All patients with self-care therapy plan on discharge, or arrange for the continuation of their rehabilitation in their own home with community team if still required.

Care Coordination

- The coordination and flow of patients through the bed is the responsibility of the Provider.
- The Provider shall ensure that patients are tracked through the system and work with Partners to ensure that patients achieve their EDD and are discharged to the right setting in a timely manner.
- Identification and escalation of any delays in the beds e.g. awaiting social care input or delays in discharges.
- The Provider shall have a delegated member of staff who shall work with T&T to manage the flow out of hospital to the community bed base and from the community bed base to the final care destination.
- The Provider shall adopt the system-wide approach of review and proactive case management of stranded/ super stranded patients, along with the implementation of community MADE (multi-agency discharge events). The Provider shall develop a quality improvement cycle for implementation across the beds.

3.3 Population covered

Patients over 18 years of age, registered with a North Staffordshire or Stoke-on-Trent GP.

3.4 Any acceptance and exclusion criteria and thresholds

Inclusion Criteria

- 3.4.1 General Nursing/ Rehabilitation – patient is deemed to require a **DST assessment** that cannot be undertaken in the patient's own home and therefore, requires a Discharge to Assess (D2A) bed. It is expected that the MDT will support the assessment consisting of a medical professional, therapy staff, social care, patient's key worker and nursing staff.
- 3.4.2 Patient requires and would benefit from **rehabilitation** (normally a continuation of a programme commenced in hospital). Rehabilitation cannot be delivered in the patient's normal place of residence (due to ongoing need for nursing care) but can be effectively and safely delivered within the proposed placement environment either by the placement provider or another provider or both.
- 3.4.3 Patients that require a period of assessment due to impaired cognition/ complex EMI needs or general confusion where it is not safe to be undertaken in the patient's own home. The Provider shall request support from the Outreach Team for these cases.
- 3.4.4 Patient is non-weight bearing and has a plaster of paris (POP) in-situ but cannot be safely managed at home because of functional limitations of having a pop in place. Access to appropriate therapy services must be available to maintain general functional status as far as possible.

Exclusion Criteria - There is an expectation that the below exclusions may be flexed in accordance with local protocol during high level of demand

- 3.4.5 Patient is under 18 years of age

- 3.4.6 Patient is not registered with a North Staffordshire or Stoke-on-Trent GP
- 3.4.7 Patient is not medically stable for discharge/ transfer from an acute hospital
- 3.4.8 Patient already assessed as having a social care need only (including housing)
- 3.4.9 Patients who have specialised nursing care needs e.g. neuro-rehabilitation

3.5 Interdependence with other services/providers

- 3.5.1 Interdependancies with other services outside of the MFT: The Provider shall use their specialist expertise to creatively develop safe and effective ways to deliver positive outcomes in collaboration with partners and by building on existing good practice and positive relationships.
- 3.5.2 The Provider shall ensure access for the patient to all relevant services as may be required in accordance with the individual needs as below, but not limited to:
 - GP Out of Hours Service
 - Allied Health Professionals
 - Social Care
 - Mental Health Services
 - Acute and Community Hospitals
 - Advocacy/ IMCA services
 - Safeguarding
 - Voluntary Agencies
 - Other Community Services e.g. Infection Control, Prevention Team, Tissue Viability, Continence.

3.6 Mortality Assurance

- 3.6.1 The Francis Report, expectations from the NHS Improvements, from Monitor and from the Care Quality Commission describe the process of mortality reviews as a key part of reviewing patient's outcomes and working towards a high quality service. NHS England detail participation in the annual publication of findings from reviews of deaths, the annual publication of avoidable death rates, and actions taken to reduce deaths related to problems in healthcare in their nine 'must do' priorities 2017-19.
- 3.6.2 The aim of this process is to identify any areas of practice both specific to the individual case and beyond that could potentially be improved, based upon peer group review. Areas of good practice are also identified and supported.
 - 100% of all patient deaths, including palliative/ end of life care, are reviewed using the Mortality Trigger Tool (attached) within 7 days of death.
 - Completed mortality trigger tools shall be submitted (via encrypted NHS.net link) to the CCG for review monthly by the CCGs Mortality Review Group chaired by the CCGs Medical Director.
 - The CCGs Mortality Review Group shall review the death categories as either 'C1: Likely outcome and all appropriate management undertaken', 'C2: Likely outcome and all appropriate management not undertaken', 'C3: Unlikely outcome and all appropriate management undertaken', or 'C4: Unlikely outcome and all appropriate management not undertaken'. If any deaths are categorised C2 or C4 then an in-depth investigation will need to be undertaken and at this stage the CCG will request further details, using the unique reference number, including the patient's NHS number. The in-depth investigation will subsequently be presented to the CCGs Mortality Review Group.
 - Any learning/ good practice identified at the CCGs Mortality Review Group will be fed back to the originating Provider and shared with other commissioned services to support quality improvements.

4. Applicable Service Standards

- 4.1 Applicable national standards (eg NICE)

- National Commissioning Board, Everyone Counts: Planning for Patients (2013-14)
- National Commissioning Board, The CCG Outcomes Indicator Set (2013-14)
- The King's Fund, Older People and Emergency Bed Use (2012)
- Department of Health, Care Closer to Home/ Our Health Our Future Review – Lord Darzi Report (DH 2007)
- Care Act 2014
- Department of Health, Direction of Travel for Urgent Care (DH 2007)
- Healthcare Commission – Urgent Care Review (DH 2008)
- Royal College of Physicians. Acute Medical Care – the right person, in the right setting – first time (RCP 2007)
- NHS Institute for Innovation and Improvement, Seven Ways to No Delays. 2010
- Care Quality Commission: Enforcement Policy (CQC 2012)
- KPMG Report Healthcare Advisory – Staffordshire Local Health Economy 2014
- Call to Action Report (2014)
- Acute Medical Care of Elderly People, BGS (2011)

Crucially services shall ensure that the recommendations set within the Francis Report as listed below are met:

- Independent Inquiry into care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2005 volumes 1 and 2 (Francis, R 2010)
- Report of the Mid Staffordshire NHS Foundation Trust Inquiry (Francis, R 2013)

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

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.11 Applicable Quality Requirements (See Schedule 4A-C)

5.12 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

6.1 The current bed base is provided at the Haywood Hospital, High Lane broken down as follows:

- Chatterley Ward - 32
- Grange Ward - 25
- Jackfield Ward – 20

*Jackfield ward is commissioned to provide nursing assessment and support for patients with EMI needs.

7. Individual Service User Placement

Specification No:	CS_37
Service	Brighton House – rehabilitation, reablement and assessment unit
Commissioner Lead	Gemma Smith
Provider Lead	Lisa Agell
Period	1 st April 2019 – 31 st March 2020
Date of Review	July 2019

1. Population Needs

1.1 National/Local context and evidence base

There are significant challenges facing the urgent care system in Staffordshire and a real drive and strong ambition to improve system working and improve the community offer. The vision is to improve outcomes and pathways for patients by developing innovative ways of working in order to change a historical reliance on traditional models of acute and community hospital-based care. To meet the needs of our population, to provide truly holistic care, to deliver services more efficiently and achieve the strategic intention to move care closer to home. This will require different models of care in the community, the transference of activity from acute and hospital-based services to lower acuity community and primary care settings where appropriate (“Shift Left”).

1.2 Current community service provision

Good progress has been made locally in recent months in redesigning the care system to provide capacity where it is needed at the appropriate level. The bed-base has been reconfigured from being an entirely NHS community hospital bed base to a mixture of community hospital, nursing, residential and specialist mental/physical health bed provision. This breakdown is outlined below:

Community Hospital Beds

There are 57 Adult Intermediate Care beds at the Haywood Hospital. These beds are a vital resource having a high level of medical, therapy and nursing cover, alongside diagnostics and a NHS hospital infrastructure within a PFI facility. It is recognised that is an expensive model and it is important that this resource is utilised effectively by patients who cannot be managed in a setting of lower dependency.

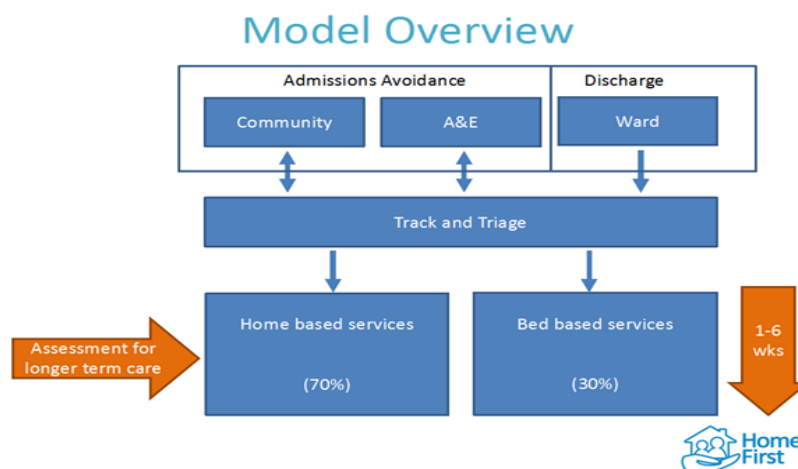
CCG commissioned step down care home and specialised mental/physical health beds

There are approximately 75 beds available in a variety of settings, including care homes and joint mental/physical health (complex patients)

Home First

The Home First model is a significant and innovative newly designed approach. Home First provides a range of integrated services and focuses on patients who are clinically optimised and no longer require an acute hospital bed but may have ongoing care and support needs. Patients are discharged to their own home (where appropriate) or another community setting (bed-base as described above) where assessment for longer-term care and support needs can be undertaken in the most appropriate setting and at the right time for the person. The services promote faster recovery from illness, prevents unnecessary acute hospital admission and premature admission to long-

term residential care, supports timely discharge from hospital and maximises independent living. An overview of the model is shown in the diagram below:



1. Outcomes

2.1 NHS Outcomes Framework domains and 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	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	x

2.2 Locally Defined Outcomes

- Placing the right patients in the right place at the right time to get the best outcome;
- Giving people the best and most appropriate support when they need it most;
- Utilising a collaborative approach to achieve shared goals;
- Using our resources to maximum benefit in line with patient need.

3.Scope

3.1 Aims and Objectives of the service

- To facilitate stepping down from acute hospital beds in a timely way to a short-stay service (maximum of 4 weeks) in a setting of the lowest level of dependency in line with patient needs, thus improving patient flow through the system;
- Delivery of a multidisciplinary model which promotes high quality, individualised care and achievement of rehabilitation goals,

- Access to services based on need, not diagnosis or clinical condition;
- To ensure that service user and carer involvement is core to the service and encourages participation;
- To provide an empowering service which is integrated with the wider care system;
- To continue therapy provision to ensure maximum reablement delivered to each and every patient;
- To promote a culture of reablement, promoting self-management, prevention and maximising potential;
- To maximise the use of available capacity to enable patients to be cared for in the setting of least dependency and reduce unnecessary delays. It is believed that a particular advantage will be the pathways with the Haywood Hospital whereby where clinically appropriate patients can be transferred to the Haywood if a higher intensity provision is needed (to avoid UHNM admission if appropriate); also patients that be more suitable for Brighton House could be stepped down from the Haywood, thereby enabling better use of resources.
- To provide the potential to respond to “failed” discharges where additional short term ongoing support is required

3.2 Service Description/Care Pathway

A system approach is the only way to achieve the scale and pace of change required and to ensure the care environment operates in a way that our patients, public and staff need and deserve. Brighton House will be an important part of the rapidly developing and improving new system of care, whereby the following principles are key:

- Discharge patients ‘home first’ with discharge to a bed as an exception only when absolutely required. If home first is not appropriate for that individual, the principle should be discharge to the bed-based setting of least dependency, i.e. a nursing home or Brighton House bed rather than a community hospital;
- Patients are assessed within the acute setting at an early stage of their admission when their physical or mental health is not at a point where an accurate assessment can be made;
- Identification of patients at an early stage in the acute Trust to ensure no avoidable decompensation in clinical condition and transfer to a community-based setting as soon as possible;
- Patients to be placed in services based on need, not capacity or demand (placing people in services other than those they have been assessed for creates blockages within the system further downstream);
- Appropriate risk management to ensure that people go straight home when they could do so;

The CCG will be commissioning 25 beds within Brighton House as part of the ongoing development and reconfiguration of community bed capacity.

From admission and during the placement, it is expected that patients will receive individualised holistic, high quality care from an integrated team, including social workers and therapists in order to continue active rehabilitation, to optimise function across all domains, including mental health and support timely discharge, to identify and assess current and future care needs, and / or to allow arrangements for on-going care to be put into place.

The service is a nurse and therapy-led community service. Medical cover will consist of a weekly MDT where all patients will be reviewed, plus GP visits (all staff with the exception of the Stoke-on-Trent social care staff will be employed directly by SSOTP as part of the service). As the majority of the patients will be aged 65+, many individuals will have joint physical and mental health needs. Therefore, the service will support patients with lower-level mental health needs who can be safely managed in this environment.

The two main groups of patients defined within the admission criteria are:

- Patients requiring a period of rehabilitation following an acute episode
- Patients requiring complex assessment and future care planning following an acute episode

Medically stable for transfer from UHNM whose needs can be met at Brighton House (the needs of bed bound, semi-acute or highly dependent patients cannot be met at Brighton House; consideration should be given to a community hospital referral)

In addition, individuals who are non-weight bearing and have a plaster of paris (POP) in-situ but cannot be safely managed at home because of the functional limitations of having a POP in place will be accepted into Brighton House.

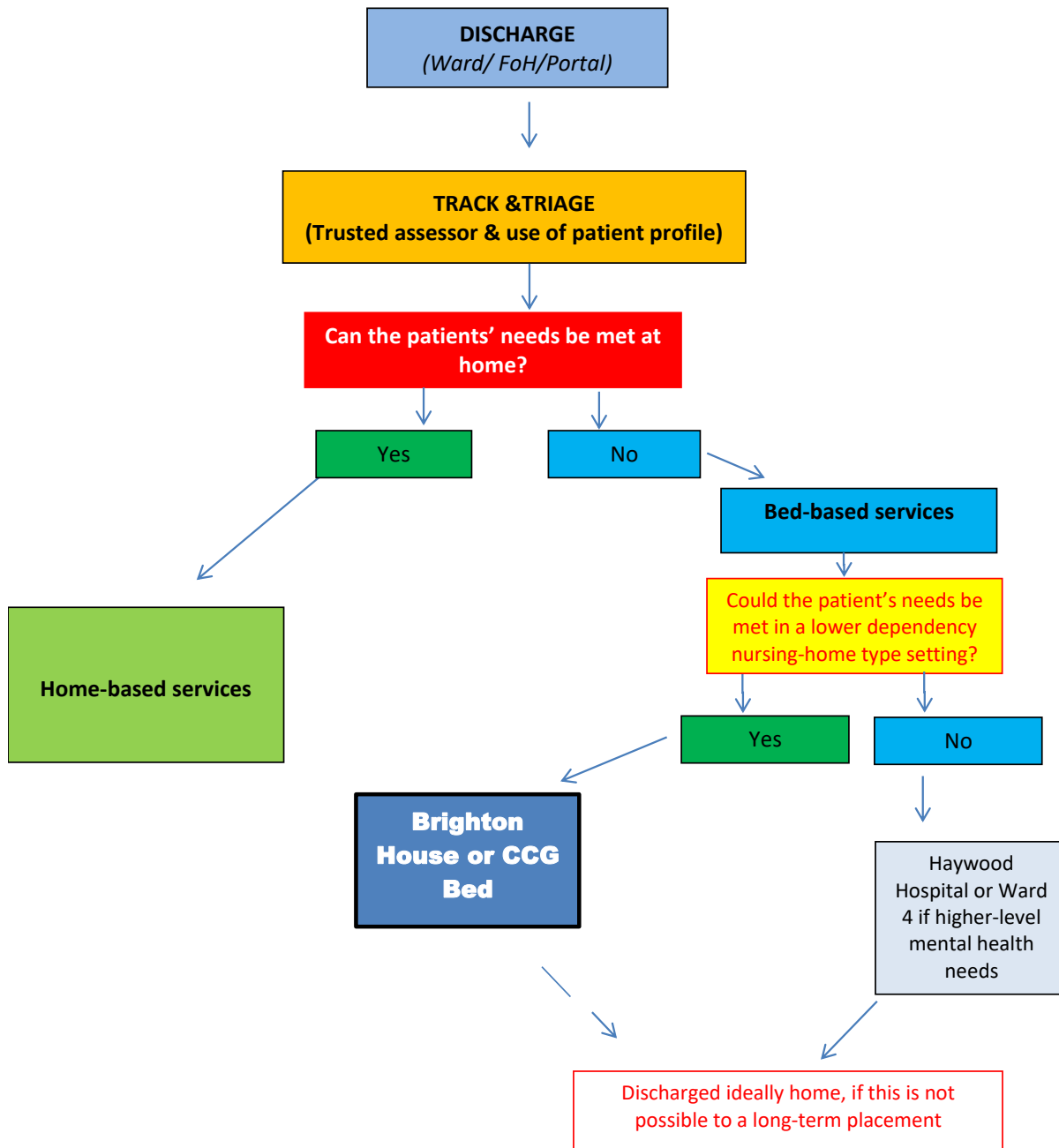
Referrals into Brighton House will be managed through the commissioned Track and Triage service.

3.3 Exclusions

- Patients who have specialist nursing care needs (for example those with complex neurological need or requiring ventilation, post stroke patients, patients with significant learning difficulties or complex needs)
- EMI requirements where a more specialised/ higher level placement may be appropriate, or if detained under the Mental Health Act (1983)
- Bariatric patients and patients with requirements for hoisting due to constraints within the physical environment at Brighton House
- End of life care patients/palliative care patients (however those not in the last 3 months of life can be safely managed)

3.4 System model

System pathway



3.5 Population covered

Patients aged over 18 years, with a Stoke-on-Trent or North Staffordshire GP

3.6 Interdependence with other services/providers

- Primary Care
- UHNM
- Track and Triage
- Home First
- Stoke on Trent City Council
- Staffordshire County Council
- Combined Healthcare
- Community Providers
- Patient Transport Service (non-emergency)
- WMAS
- Voluntary sector
- Nursing and Residential Care Homes
- Out of Hours
- 111
- Integrated Community Equipment Service

4. Key Performance and Information requirements

KPI	Reporting frequency
% occupancy of unit	monthly
LOS for each patient	monthly
Discharge destination on admission	Monthly
Actual discharge destination	monthly
Outcome measure on admission	monthly
Outcome measure on discharge	monthly
Number of patients transferred back to acute trust	monthly
Number of patients stepped up to CH	monthly
Number of patients that were discharged before their EDD	monthly
Patient satisfaction KPI's to be included x 3 (normal ones)	monthly

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	CS_41	
Service	Rheumatology	
Commissioner Lead	Sharon Cooper	
Provider Lead		
Period		
Date of Review		
1. Population Needs		
1.9 National/local context and evidence base		
Rheumatology is a multidisciplinary specialty which deals with the investigation, diagnosis and management of patients with arthritis and other musculoskeletal conditions. There are over 200 disorders affecting joints, bones, muscles and soft tissues, including inflammatory arthritis and other systemic autoimmune disorders, vasculitis, soft tissue conditions, spinal pain and metabolic bone disease. This specification covers the investigation, diagnosis and management of patients with Rheumatological conditions that are not currently covered under NHS England Specification for Specialised Rheumatology Services (Adult) Rheumatological disease affects over 16 million people within the UK (National Rheumatoid Arthritis Society June 2013) and impacts across all ages. Currently within the Northern Staffordshire area it is believed that 30% people present to their GP with a musculoskeletal problem caused by an underlying Rheumatologic disease, accessing primary, secondary and community services to diagnose and manage their condition. NICE guidance (2013) indicates that there is evidence that there are unnecessary delays between first presentation of symptoms and subsequent diagnosis of rheumatoid arthritis. In addition to this patients do not always receive optimum treatment outlined in NICE guidance due to delays within the system. A local review of the Rheumatology service has been undertaken which identified the need to revise the provision of long term monitoring of patients applying the closer to home premise.		
2. Outcomes		
2.1 <u>NHS Outcomes Framework Domains & Indicators</u>		
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

The expected outcomes from this service include:

- Enhanced patient and carer experience, satisfaction and quality of life
- Direct access to Advice and Guidance for all GP's will be available
- Delivery of a service that enable patients and their carers to obtain information, knowledge and skills to facilitate self-care, wellbeing and to promote independence
- Responsive and timely access to a service that supports patients to proactively access the service in a location of their choice
- To provide a service that is equitable for all patients across North Staffordshire and Stoke on Trent
- Improved health and quality of life for patients

3. Scope

3.1 Aims and objectives of service

- To provide a community-based, cost effective, accessible specialist in-patient; out-patient and Day Case rheumatology service which includes the diagnosis, treatment, and holistic management of adults in line with the agreed access criteria, responding to changing medical and social needs of the user.
- To deliver a service that focuses on and facilitates the treatment and rehabilitation of the patient.
- To provide access to high quality, safe care that gives timely advice, appropriate support, assessment, diagnosis and treatment for patients according to their individual need.
- To ensure the service is delivered in line with current policy, learning and best evidence and complies with relevant national guidelines.
- To ensure that the quality of service delivered is continuously improved .
- To ensure that the services are geared to the needs and concerns of the local population.
- To support service user involvement in both practice and service development.
- To continue to develop areas of outcome measures, audit and goal planning.
- To maintain an open and honest culture where feedback, whether this be in the form of complaint or comment, is encouraged and acted upon.
- To develop a relationship, on a managerial and clinical level, based on mutual trust, honesty and integrity;
- To provide a service that provides high quality advice and information to service users and/or their carers.
- To ensure that the services are geared to the needs and concerns of patients and their families including delivering care within appropriate locations.

3.2 Service description/care pathway

It is expected that the provider should deliver the following:

- All referrals will be triaged by a consultant or specialist nurse upon receipt and validated against the exclusion criteria.

- All patients to be offered an outpatient appointment within 6 weeks of the referral being received into the service unless suspected rheumatoid arthritis which will be seen within the current guidelines of 3 weeks
- Urgent new appointments should be available and allocated against agreed clinical criteria for urgent needs
- Treatment where deemed appropriate will be commenced within 6 weeks of referral in line with the Best Practice and National Guidelines
- Urgent follow up appointments should be available for patients with exacerbation of their disease within 3 weeks if clinically appropriate
- The service will provide a 24 hour 7 day on call service for rheumatology emergency and inpatient reviews across the economy
- Each patient should have named consultant(s) as their 'case manager' who is responsible for the development and maintenance of an evidence based care plan for all service users to ensure continuity of care is delivered.
- Each patient must be fully educated in self-care and management and robust patient education plans must be put in place by the service.
- An SOS/nursing telephone service to support patients during their pathway of care will be provided and information made available within the patients documentation
- The provider will deliver a community based rheumatology service to support patients in their own home where criteria are met
- The provider will work towards a shared care pathway with Primary Care The provider will ensure that there is a governance pathway in place in relation to the delivery of key competencies and standardisation of treatment.
- MDTs and Peer Reviews should be an integral part of the service and should be recognised as core and best practice.
- All patients on the caseload will be actively monitored as required in keeping with national guidelines.
- Patients that remain on the caseload will have access to an annual review. These reviews will be led by specialist nurses with access to medical support if required
- Where clinically appropriate patients will be discharged back to their GP
- Ensure appropriate numbers of patients are booked into all clinic sessions to maximise capacity in keeping with national agreed guidelines
- Ensure effective management, of waiting lists and waiting times via an appropriate clinic booking system and the implementation of efficiency measures in all clinics in order to reduce unnecessary delays within the system
- Implement a strategy for identifying and reducing DNA rates in all clinics, including appropriate solutions to minimise and prevent missed appointments and to reduce wasted staff time i.e. the use of text reminder service
- Interface / joint work with other appropriate services including musculoskeletal, orthopaedics, elderly care, renal, pain management, AHP, respiratory, dermatology, paediatrics, neurology and secondary care surgical provision including the provision of multi/ interdisciplinary clinics where appropriate
- Deliver basic training for primary care staff
- Use the results of the patient survey to develop and improve the service experience
- Deliver services in line with professional guidance and national best practice
- Ensure patients are integral to the design and on-going development of the service

It is expected that this service will offer a comprehensive range of assessments and treatments for patients tailored to take into account the needs of the local population. The Service Provider should be aware of issues of diversity, (e.g. the service should take into account the cultural diversity of the local population and the differing issues faced by patients living in rural communities).

The service provider will be innovative and strive for continual service improvement covering the following areas:

Advice and Information

The Provider shall ensure that they provide patients with:

- Written information about the service, available in numerous forms
- Information about other local services and groups
- A clear patient leaflet, in multiple languages. Written and verbal information in regards to maintain and monitoring their condition.
- Information for carers regarding local support and information
- Information about transport services.
- The provider should provide evidence of engagement with patients and national patient groups in development and delivery of rheumatology services

Providing written information may not always be the most suitable way for all patient groups, therefore the Provider shall use different ways of delivering self-management guidance including verbal and over the telephone advice. Advice and information must be accurate, up-to-date, consistent and easily accessible. This requires a regular review of knowledge and the appropriate training and supervision of staff, including administration and reception staff and ward staff.

Appointment times and allocations

The provider should ensure that there is a clear protocol for booking appointments and that there is a dedicated telephone line manned at specified hours and an answer phone service available during call hours should a member of staff not be available. Advice and queries should also be able to be submitted via Advice and Guidance on Choose and Book and responses returned with appropriate timescales. Information in regards to this should be readily available to patients and their carer's.

Waiting Times

The provider should ensure that an effective system is in place to work within the maximum waiting times set out within this specification.

First to Follow Up Ratio

Maintaining appropriate follow up of rheumatological conditions as per national guidance. Monitoring will be developed in year to monitor against national guidance through an agreed set of KPIs.

Daycase and Outpatient Procedures

The service will also be expected to deliver day case and outpatient procedures as part of individual care pathways. Daycase should only be charged where the clinical complexity of the procedure and/or patient means that the procedure cannot be undertaken in an outpatient setting.

Medicines Optimisation

The Provider is expected to comply with NICE recommendations regarding Category 1 drugs ensuring that they are only used as per NICE criteria and will require a completion of a continual assurance request (CAR).

Monitoring

It is expected that the monitoring element of the service will be Rheumatology based and will be supported at a primary care level with in-put as and when required. Clinical Pathway



Inflammatory Arthritis - Suspected

3.3 Population covered

Eligible patients shall be registered with a North Staffordshire or Stoke on Trent CCG GP. The provider should negotiate any out of area activity with individual commissioners.

The service will be provided in a range of geographical locations across Northern Staffordshire to ensure equity of access and enable patients to attend a programme as close as is reasonably possible to their home.

3.4 Any acceptance and exclusion criteria and thresholds

All referrals into this service must meet the clinical criteria agreed across primary care and the Rheumatology service.

Exclusions

Patients who do not meet the access criteria for the Rheumatology service

Patients whose clinical need would be better suited to the services of Orthopaedics or the MSK service.

3.5 Interdependence with other services/providers

The Provider shall ensure that:

- All premises are compliant with Health and Safety regulations, Disability Discrimination Act (DDA) requirements and that a risk assessment is undertaken annually.
- The locations from which the service is provided are easily accessible by public transport; which patients must be made aware of. The Provider shall ensure that all clinic locations have adequate parking facilities nearby.
- All premises meet high cleanliness and infection control standards and must provide for the maintenance of patient privacy, dignity and confidentiality, in compliance with Care Quality Commission standards. The Provider shall ensure that the service location provides full disabled access and facilities such as disabled toilets and suitable waiting areas.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

TA195 Rheumatoid arthritis - drugs for treatment after failure of a TNF inhibitor

TA225 Rheumatoid arthritis (after the failure of previous anti-rheumatic drugs) - golimumab

TA247 Rheumatoid arthritis - tocilizumab (rapid review TA198)

- NICE quality standard 33: rheumatoid arthritis

- NICE clinical guideline 79: rheumatoid arthritis
- NICE commissioning guide on biologic drugs for the treatment of inflammatory disease in rheumatology, dermatology and gastroenterology

And any additional NICE Guidelines, Technology Appraisals, Medical Technologies and Diagnostics Guidelines, Interventional Procedures Guidance

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

- Managing People with Long Term Conditions The Kings Fund (2010)
- Perceptions of patients and professionals on rheumatoid arthritis care The Kings Fund (2009)
- Arthritis Care Three wasted years; evaluating the progress in delivering improved rheumatoid arthritis services Arthritis Care (2012)
- National Collaboration Centre for Chronic Conditions: Rheumatoid arthritis. National clinical guideline for management and treatment of adults RCP (2009)
- National Audit Office Services for people with rheumatoid arthritis (2009)
- House of Commons Committee on Public Accounts (2010)
- Best Practice Tariff for early inflammatory arthritis DOH (2013)
- NHS Evidence : Self Care support for long term conditions (2009)
- EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease modifying anti- rheumatic drugs Smolen J etal (2010)
- Transforming our Health Care Systems The Kings Fund (2013)
- Standards of Care. Inflammatory Arthritis ARMA (2004a)
- 18 week commissioning pathway Inflammatory Arthritis (joint pain) Rheumatology Futures Group (2009)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.13 Applicable Quality Requirements (See Schedule 4A-C)

5.14 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Haywood Hospital
High Lane , Burslem
Stoke on Trent
Staffordshire ST6 7AG

7. Individual Service User Placement
