

APPENDIX 2A: SCHEDULE 2 – THE SERVICE Service Specifications

Ref No.	Services Provided	Geography for service provision*
CS_10	Children and Young People Targeted (Health) Intervention Service	<ul style="list-style-type: none"> • Stoke-on-Trent
CS_24	Community MSK Service (IPOPS)	<ul style="list-style-type: none"> • Cannock Chase • South East Staffordshire & Seisdon Peninsula • Stafford & Surrounds
CS_31	Integrated Specialist Long Term Conditions Service	<ul style="list-style-type: none"> • North Staffordshire • Stoke-on-Trent
MICATS_01	MICATS – Community MSK Service	<ul style="list-style-type: none"> • Cannock Chase • Stafford & Surrounds

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.

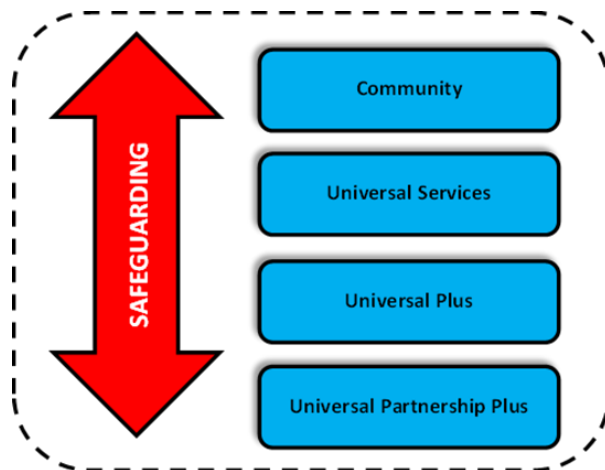
The NHS Atlas of Variation indicates that children and young people in Stoke-on-Trent in general have significantly poorer health outcomes than the national average, for examples high levels of admissions of asthma, diabetes, epilepsy and lower respiratory tract infections.

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:

<p>Universal Plus (individual/ targeted needs led)</p>	<ul style="list-style-type: none"> • 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. 	
<p>Universal Partnership Plus (Vulnerable or Complex Families)</p>	<ul style="list-style-type: none"> • 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 	
	<p>undertaking review health assessments within statutory timescales and guidance.</p> <ul style="list-style-type: none"> • 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_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 2020¹
- 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	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

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/>

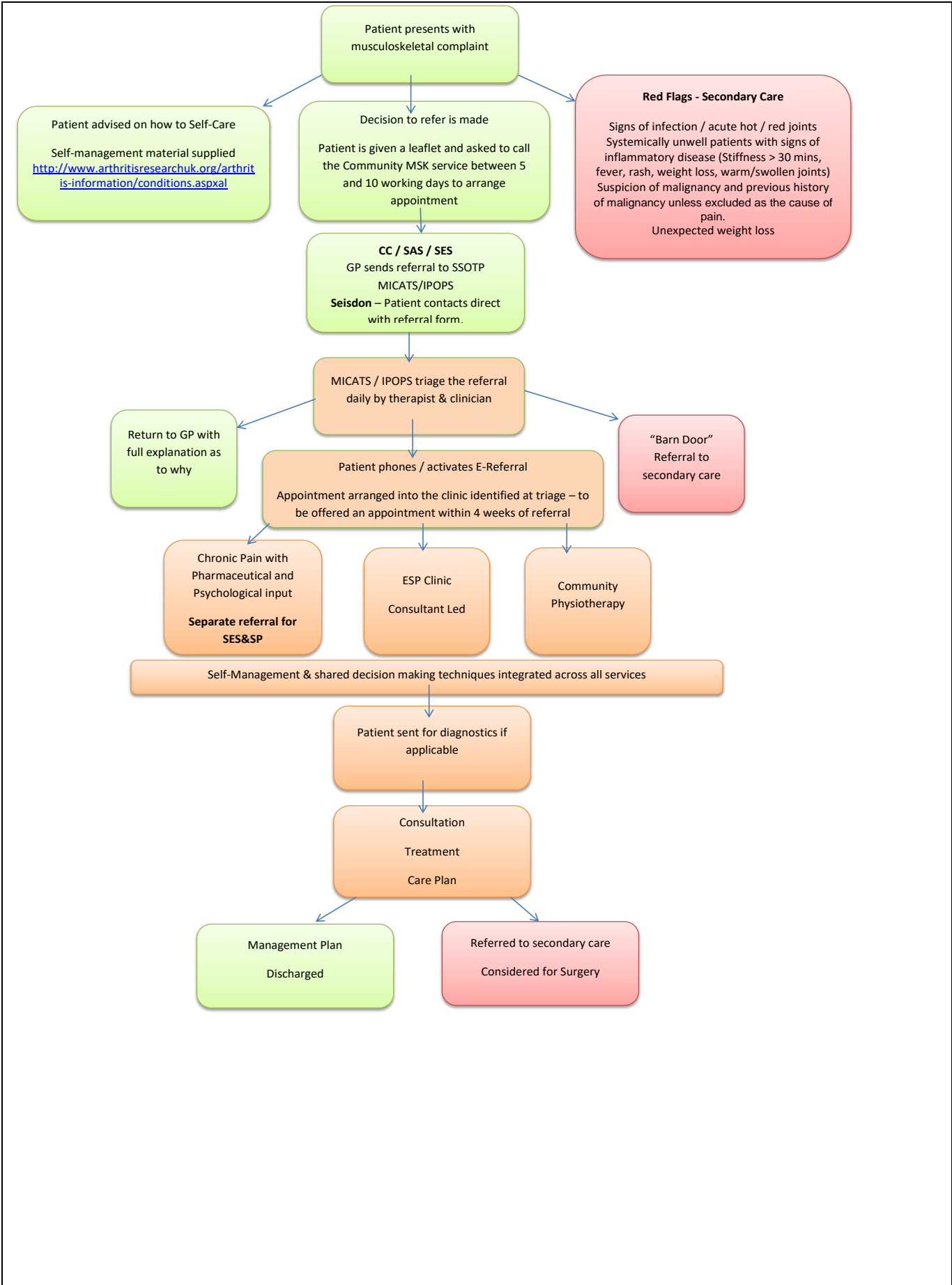
Post treatment complications

- 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

5.1 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 choses 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 wit supporting detail	Audit	6 monthly audit	Issue of Contract Performance Notice and subsequent process in accordance with GC9	6 monthly	Community MSK Service

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: See appendix one for MSK Data Headings	Submit to Coordinating Commissioner within 15 Operational Days of the 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.	

5.2 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 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

5.3 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 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 2020²

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	<input type="checkbox"/>
Domain 3	Helping people to recover from episodes of ill-health or following injury	<input type="checkbox"/>
Domain 4	Ensuring people have a positive experience of care	<input type="checkbox"/>
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	<input type="checkbox"/>

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

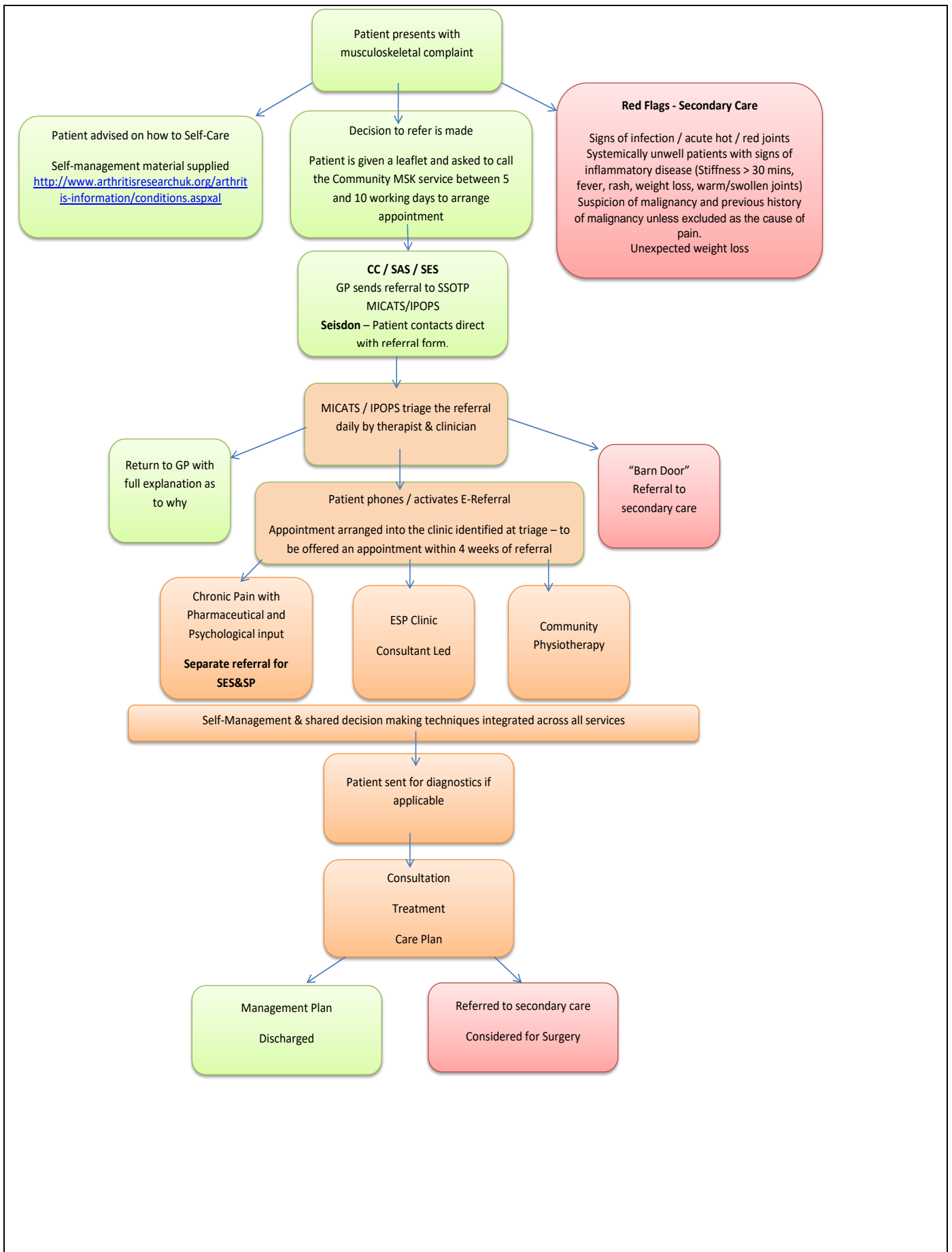
- 3.3.10 The management of complications such as wound infection procedures undertaken by the Provider shall be the responsibility of the Provider. These Service Users will be seen as an emergency at the next available clinic appointment if clinically appropriate and should secondary care management 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 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

- 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

1.3 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.