SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	001
Service	Out of Hospital Community Services contract: Core Specification A Access, Navigation and Self-Care B MOSAIC C Long Term Conditions D Integrated Care E Care Homes Nursing F Continuing HealthCare G Infection, Prevention and Control H Specialist Paediatric service I Homeless Health Team (until 31/1/20) J GP Interpreting and Translation (until 31/12/19) K PLT admin service (until 31/5/19) L Property Support Services (TBC)
Commissioner Lead	NHS Nottingham City CCG
Provider Lead	Nottingham CityCare Partnership CIC
End Date	1 July 2018 – 31 March 2025 (not including 2 year optional extension) (unless otherwise stated)
Date of Review	6-monthly

1. Population Needs

1.1 National/local context and evidence base

During the contract life term Nottingham City CCG will become part of an Accountable Care System (ACS) across Nottinghamshire/Greater Nottingham. The ACS will be a place based-system of health and social care in which organisations accept joint and several accountability for the triple aims of improving the health of the population, quality of services and managing the common resource: the ACS will be a single risk bearing entity to managing the entire care continuum. The successful Provider must form part of the ACS and as part of this will be expected to help shape and deliver its part of the single risk bearing entity. The successful Provider will also be expected to work with a Care Integrator whose role will be to be part of bringing about support and facilitate the successful delivery of a the new model of care in England.

The implementation of the ACS will involve a variation to the contract and may involve the transfer of the contract to another Provider or the Care Integrator in the place of the CCG. The successful Provider will remain responsible for the provision of the services but will provide the services as part of the ACS described above. The contract terms and conditions will describe the evolution to an ACS and the need for a future modification to the contract and will require the successful Provider to provide its consent to the potential future transfer of the CCG's role under the contract (such consent to be accordance with General Condition 12.10 of the contract).

The Nottingham and Nottinghamshire Sustainability and Transformation Plan (STP) aims to:

- Close the gaps identified in the NHS Five Year Forward View relating to health and wellbeing, care and quality, and finance and efficiency.
- Tackle the high impact issues which will deliver the most return and support implementation of local innovations, in areas such as collective approaches to workforce and organisational development.
- Ensure organisations are working together on changing cultures and health behaviours to maximise the benefits from new initiatives like self-care and promoting independence.

Closing the gap: health and wellbeing
The STP has been produced for local patients/citizens, with local patients/citizens, addressing the needs of patient/citizens, service users, carers and local communities. The population covered by the STP is diverse, growing and ageing. Through previous engagement, patients/citizens have communicated that they want support to stay well, be independent and able to self-care wherever possible. The STP makes a compelling case for change to collectively prevent the causes of ill health, thereby reducing demand for services and tackling health inequalities. Organisations involved in the STP will link in with local health and wellbeing strategies and intelligence from the joint strategic needs assessments, to aim to reduce smoking prevalence, obesity, and the impact of alcohol and drugs. The aim of the plan is to empower patients/citizens to adopt and maintain healthy lifestyles and behaviours, manage ill health and promote good health and wellbeing.

Closing the gap: care and quality
The STP seeks to achieve consistent and equitable standards of care for the local population. There will be a single approach to quality and sustainable acute care provision focused on preventative, proactive care with more services provided in or closer to home. All partners are committed to the further reshaping of services and resources away from hospital towards the community, social care, voluntary support and primary care development.

Closing the gap: finance and efficiency
The city and county health and social care economy, like the rest of the country, faces significant financial challenges in the future if action is not taken now. The STP requires an alignment of financial resources and incentives, with collective decision making about where resources are best placed. Future payment mechanisms will be more closely linked to outcomes. Certain care pathways and services will be transformed where there are opportunities for greater value for money. Critical to achieving financial balance in the long term is the need to promote self-care and independence, reducing the reliance on services (while improving the patients/citizens experience).

The STP has established four key areas where it aims to achieve high impact changes within Nottingham and Nottinghamshire:

1.Prevention and promoting independence
Looking at how we can empower people to be healthier at all points in their life.

2. Primary and community care
Reducing hospital admissions of people with long-term conditions, supporting prevention at all stages of someone's care and the early identification and effective management of early disease. This also includes supporting clinicians access the most appropriate services for their patient/citizen, developing primary care, and increasing collaborative and proactive care with a focus on personalised budgets.

3. Urgent and emergency care
Ensuring appropriate use of A&E, an urgent response for patients/citizen in crisis, improving transfers of care and discharge, and improving navigation, advice and information for patients/citizens and professionals.

4. Technology enabled care

Supporting technology enabled practice, care and prevention. This includes better sharing of information and joint trusted assessor roles, increasing use of assistive technology to support independence, and providing information and advice to enable prevention, self-care and wellbeing.

A series of enabling and supporting themes have been established within the STP:

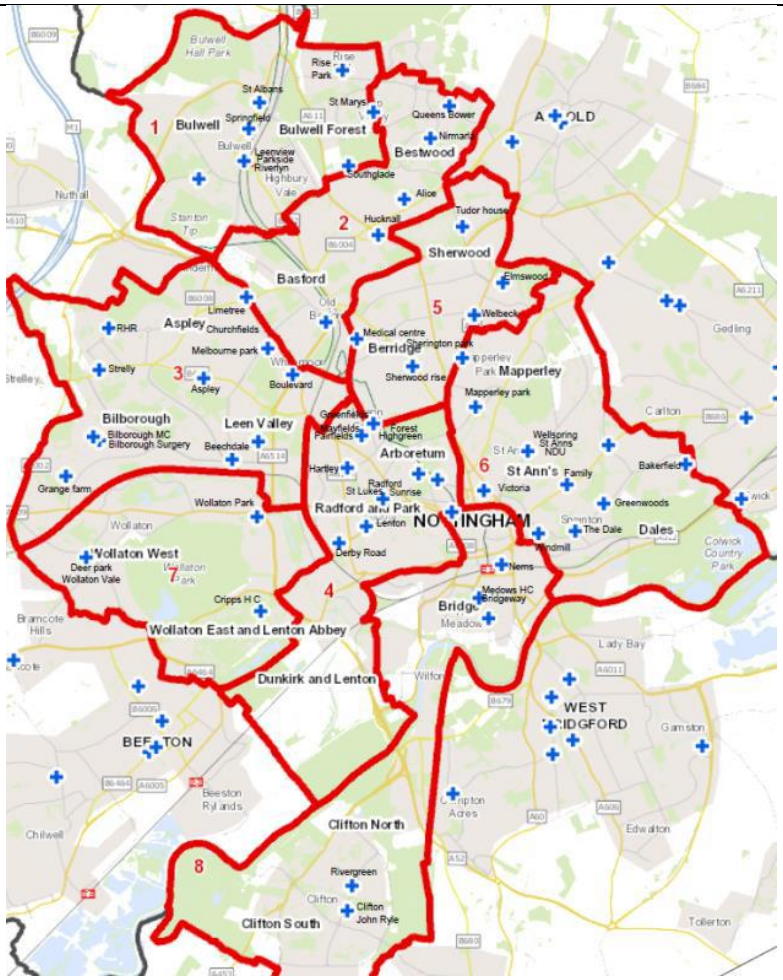
- Clear, consistent and evidence-based care pathways
- Improved outcomes for individuals with mental health needs or learning disabilities
- Self-care and carers support
- Workforce and organisational development
- Estates

The **Next Steps Five Year Forward View** (2017) outlines that:

'*As people live longer lives the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital stays where possible. To improve prevention and care for patients/citizens, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes.*

We … want to accelerate this way of working to more of the country, through partnerships of care Providers and commissioners in an area (Sustainability and Transformation Partnerships). Some areas are now ready to go further and more fully integrate their services and funding, and we will back them in doing so (Accountable Care Systems). Working together with patient/citizens and the public, NHS Commissioners and Providers, as well as local authorities and other Providers of health and care services, they will gain new powers and freedoms to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover.

NHS Nottingham City CCG is split into 8 Care Delivery Groups across which services, premises, staff and monitoring will be delivered.



1. – Bulwell and Bulwell Forest
2. – Basford and Bestwood
3. – Aspley, Bilborough and Leen Valley
4. – Arboretum, Dunkirk, Lenton and Radford and Park
5. – Berridge and Sherwood
6. – Dales, Mapperley and St Ann's
7. – Wollaton East and Lenton Abbey and Wollaton West
8. – Bridge, Clifton North and Clifton South

The **Nottingham City Primary care Network (PCN) summary** profiles identify that:

- There are just over 355,000 patients/citizens registered with Nottingham City practices of which 52% are male.
- Due to the large number of students, the city as a whole has a relatively younger population profile
- Black and Minority Ethnic (BME) groups within the city form just over a quarter of the resident population. This is around 14% higher than the national average
- Asian/Asian British ethnicities form the predominant BME groups in the city
- There are high levels of unemployment and high levels of poor health and disability within the city which are significantly higher than nationally
- Local data indicates smoking prevalence is high (over a quarter of residents) and a high proportion of the adult population are overweight or obese (just under half)
- There is a significantly higher increase of cancer within Nottingham City. Looking at the incidences of breast, colorectal and prostate cancer these are all similar to the national average, it is lung cancer that is significantly higher than nationally.

Further information and a breakdown by PCN can be found at:

http://www.nottinghaminsight.org.uk/

The **Joint Strategic Needs Assessment (JSNA)** chapters on the Nottingham Insight website contains information on Long Term Conditions and disease areas, population groups and relevant chapters relating to the health and social care needs of Nottingham City, including, but not exclusive to:

Cardiovascular disease	Asylum seekers, refugee & migrant health
Cancer	Dementia
COPD	Care Homes
Diabetes	Domestic Violence
End of Life	Excess winter deaths
Musculoskeletal problems	Falls and Bone health
Stroke	Diet and Nutrition

As well as interventions such as diet and nutrition, physical activity, smoking cessation and tobacco control, obesity and mental wellbeing.
http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA.aspx

Social Value

The Provider will ensure that it supports the CCG's commitment to Social Value. This includes how the Provider will give back to the community by understanding the needs and issues of the local population and working with the local voluntary and community sector. (Refer to Document 7).

The Provider will deliver Social Value by supporting the three priority areas:

- **Improving employment and training**: Supporting people who are NEET (Not in Education, Employment or Training) into employment and development, to improve physical and mental health and wellbeing.

- **Promoting healthy lifestyle behaviours**: Encouraging healthy lifestyle choices and behaviours that support the prevention of ill-health.

- **Supporting a healthy environment**: Working towards a cleaner, safer environment that supports the health of our population and is sustainable for future generations to enjoy.

Examples of how this could be supported can include (but is not exhaustive):

On the job training and workforce development; links with colleges, universities and training Providers to promote apprentice schemes or befriending schemes; links with leisure facilities or walking groups (for patients/citizens and staff); links with slimming groups or healthy eating classes (for patients/citizens and staff); links with peer support groups; promoting active travel and providing salary sacrifice opportunities for staff to travel on public transport, for purchasing ultra-low emissions vehicles, or bike to work schemes; promoting electric or low emission vehicles for business use; utilising local suppliers for food, linen and other resources; promoting smoking cessation and delivering alcohol Identification and Brief Advice (IBA) (for patients/citizens and staff) etc. This will help to support and improve the health economy of the City, not just the health of its patients/citizens. The CCG welcomes innovation and creative thinking of how Social Value can be embedded in the contract.

The Provider will be required to provide information on how these priorities will be achieved and maintained, as well as updates on how these are being met as part of an annual report.

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

Overarching Patients/citizens outcomes…
The statements below have been developed following extensive engagement with public and patients/citizens from both within Nottingham City over the last 2 years, including a recent patients/citizens Centred Outcome Measure project, and from national patients/citizens Reported Outcomes findings.

These statements will form the centre of our contract and will be measured through a variety of ways including the Invitation to Tender document as part of the procurement; through Key Performance Indicators, the Quality Schedule and the Outcomes Framework/Local Incentive Scheme within Schedule 4 of the Particulars:

"I want to be treated by services who will recognise the importance of both my emotional and psychological needs"

"I want my care to be planned with me, is centre on my needs and is inclusive of my family and carers"

"I want my care to be coordinated across health, social care and third sector services"

"I want my carer to have their needs recognised and are given support to care for me"

"I have access to information about services, support, care, illness and health promotion that is relevant, useful, sensitive, up-to-date and available in different formats"

"I am given practical and emotional support including access to statutory and voluntary sector services"

"I want to be treated by staff who are prepared and informed about me, my care needs and other services"

"I want staff to provide me with time to talk, ask questions, discuss issues and options, and give me explanations and information that is understandable and useful"

"I want good assessment and planning on discharge from hospital so it is as smooth as possible"

"I want staff who are effective at communicating and sharing information with me and also with other staff within and across health, social care and third sector services"

"I want to be treatment by staff who will maintain my confidentiality, privacy and dignity and who treats everyone with respect"

"I want to feel informed and given options and take part in decisions about my health with those who care for me"

"I want to be treated by services that are easily accessible, responsive, offer choice and that provide timely treatment and care"

Overarching System outcomes…
These system outcomes have been developed following regular data analysis of patients/citizens flow across Primary and Secondary Care and will form part of the activity and performance monitoring within the contract:
Reduced unplanned attendances to acute care (ED and Outpatients)
Reduced unplanned (re)admissions to acute care
Reduced unnecessary length of stay in acute care
Reduced unnecessary GP appointments
Improved integration with other services
Improved options for Self-Care and self-management techniques

The contract will be subject to a Local Incentive Scheme/Outcomes Framework which will set out 4 indicators in year one with the expectation that additional outcomes and indicators will be developed jointly as the contract matures and demands an increased financial value. Please refer to Schedule 4E – Local Incentive Scheme

3. Scope

3.1 Aims and objectives of service

The Out of Hospital Community Services Contract will provide high quality evidence based integrated services that anticipate and respond to the needs of patients/citizens across Nottingham City (and south county where applicable).

The Out of Hospital Community Services Contract will support delivery of the recommendations from Nottingham City's Next Phase of Integrated Care. (Refer to Document 10).

As such the objectives of the service are to:

- Minimise duplication, ensure effective use of resources, and optimise the collective benefit to patients/citizens from services and informal carers (e.g. family and friends) involved in their care. Deliver a seamless service that is centred around the patients/citizens, contributing to maximising independence and quality of life including pro-active support, planning and management of conditions.

- Work with commissioners and partners to ensure high quality, clinically and cost effective, evidenced based services are delivered within agreed care pathways. Provide co-ordinated, integrated community healthcare services to improve the health, wellbeing and lives of patients/citizens. Reduce length of acute stay, facilitate discharge and/or avoid admission where clinically appropriate.

- Empower patients/citizens to be actively involved in making decisions about their care. Contribute to improved emotional and mental health and wellbeing of patients/citizens and their carers. Proactively offer provision in a clear and transparent way to ensure patients/citizens do not have to ask for the care and support that they need.

- Provide streamlined access and equity of care provision for patients/citizens. Offer choice wherever possible, including access to Personal Health Budgets (PHB). Provide early intervention, prevention and treatment that aims to reduce avoidable admissions and/or exacerbations.

- Ensure a sustainable and motivated workforce with the right skills in the right place at the right time, every time. Ensure effective safeguarding is embedded across the provision.

3.2 Service description/care pathway

The service will provide integrated and sustainable core and specialist care delivered via a flexible and agile network of community based services, including nursing care, therapies and supported self-care.

The service will provide streamlined access and co-ordinated assessment, treatment and review, supported by integrated personalised care plans, shared records and communication across integrated care pathways so that patients/citizens experience a seamless service that is centred around the patients/citizens promoting privacy and dignity, independence and quality of life.

Care will 'follow the patients/citizens' and will include in-reach into hospital where appropriate to facilitate joint management plans, facilitated discharge and multi-disciplinary working.

The Out of Hospital Community Services Contract will be underpinned by:

- Effective leadership and a streamlined management structure, including appropriate specialist clinical leadership.
- A culture of continual improvement and innovation.
- Open and transparent collaborative relationships and co-production with commissioners, partners, patients/citizens and carers.
- A multi-skilled and multi-sector workforce.
- Streamlined assessments, reviews and clinical activity.
- Best practice and evidence based care
- Shared information and records and effective use of systems and processes e.g. administration tasks.
- Regular and effective communication with GPs
- Innovative use of technologies.
- Streamlined and consistent performance and outcome monitoring and reporting.

Transformation and continual improvement

This specification requires the Provider to commit to continual improvement, transformation and innovation by working collaboratively across interfaces, including but not limited to acute health services, community and social care services, mental health, third sector services, General Practice and commissioners with the aim of integrating care for patients/citizens.

The Provider will:

- Continually work towards improvement and development across the whole system to achieve better experience and outcomes for patients/citizens.
- Fully co-operate in reviewing and improving/re-designing care delivery at the request of and with the involvement of the Commissioners, partners and patients/citizens/carers. This will inform future service requirements.
- Ensure that there are effective systems and processes to support the collection, analysis and timely reporting of high quality, accurate and meaningful data and

information. Date and information should demonstrate effective care delivery and outcomes in order to build an evidence base to inform future assessment of need and commissioning arrangements.

- Continually improve the quality of care delivery, for example, in response to audit (undertaking and completing the audit cycle), user and staff feedback (complaints, compliments, suggestions) and incidents.
- Gather Patients/citizens Centred Outcome Measures (PCOM) through regular engagement with the local population
- Continually review and be aware of new and emerging guidance and recommendations and developments (e.g. local care pathways) and take the appropriate steps to assess and improve care delivery to achieve evidence based best practice.
- Produce and implement plans that demonstrate how it will improve performance in achieving outcomes and meet increasing needs within its resources.

Care Pathways

The Provider will be expected to develop/adopt specific clinical care pathways and guidelines to support evidence-based, cost and clinically effective service delivery and best practice.

This section describes the care delivery of the Out of Hospital Community Services Contract in which clinical specific elements are embedded. Clinical detail for each element can be found in sub-specifications:

A. Access, Navigation and Self-Care
B. MOSAIC
C. Long Term Conditions
D. Integrated Care
E. Care Homes Nursing
F. Continuing HealthCare
G. Infection, prevention and Control (independent contractors)
H. Specialist Paediatric Services
I Homeless Health Team
J GP Interpreting and Translation
K PLT admin
L Property Support Services (TBC)

Self-Care

The core purpose of self-care and independence is to facilitate patients/citizens to self-care and self-manage their conditions enabling them to retain their independence as much as possible. Patients/citizens must be educated to give them the knowledge they need to self-care and self-manage their condition (including taking into account their level of health literacy) and giving them the confidence to do so.

'Making Every Contact Count' (MECC) is premised around the day to day interactions that can support people to make positive changes to their physical and mental health and wellbeing. When these are achieved patients/citizens are able to take responsibility for their self-care and self-management. Embedding the 'Making Every Contact Count' ethos into every patients/citizens consultation will promote the identification of additional support structures that can improve patients/citizens outcomes.

Information and advice services

Information, advice and resources will be provided to patients/citizens. Strong links with acute and community health services will facilitate this. Information and advice will be readily available in venues, times and formats to best meet the needs of patients/citizens and their

carers e.g. available in a range of languages and formats suitable for the diverse population groups accessing the service, including on-line and face-to-face. The service will be widely promoted.

Access and referral management

- There will be a clear point/s for receipt of electronic and telephone referrals, working to develop a single referral template incorporating all relevant information.
- There will be an opportunity for supporting information, such as previous assessments, to be shared as part of this.
- Appropriate referrals will be accepted from GP's, community and acute health and social care professionals, and third sector services.
- Self-referrals will be accepted where appropriate.
- Telephone advice to support referrals will be available.
- All referrals will be acknowledged and information will be shared with the patients/citizens, the GP and referrer regarding the referral and assessment processes. Mechanisms will be in place to enable referrals to be triaged 7 days a week, 365 days a year in order to facilitate safe timely discharge from the acute setting and/or support avoidance of acute admission/attendance.
- The Provider will train and support the wider workforce, including GPs, to make appropriate referrals.
- In Nottingham City it is anticipated that the Provider will align the Out of Hospital Community Services Contract point of access with other Nottingham City points of access for community services, for example within the life of the contract the Provider may be expected to work with Nottingham City Council's Health and Care Point with timescales to be agreed with commissioners.
- Where patients/citizens are declined at the point of referral the Provider will support the individual and the referrer to understand the reasons they are not eligible for the service and support them to access alternative services or support. This may include making a referral to these services on behalf of the patients/citizens as appropriate and/or supported access/signposting to other local services.

Triage

- Referrals will be triaged by appropriately skilled professionals
- Additional information will be collected by the service, including copies of previous assessments, in order to complete triage.
- Triage will be supported by a clear governance process (such as detailed algorithms, clear assessment criteria and information sharing agreements).
- Triage will be available 7 days a week, 365 days a year to facilitate safe timely discharge from the acute setting and/or support avoidance of acute admission/attendance where clinically appropriate. The Provider will prioritise assessment and provision of care based on clinical need.
- Core information will be recorded once and shared appropriately across referral, triage, care planning and delivery of interventions.
- It is expected that call operators, care coordinators and clinical triage staff will be trained to communicate with the patients/citizens effectively to understand their holistic needs based on questions such as "what does a good day look like?" rather than just asking for a name and address, to ensure that onward referrals to other local services can be facilitated if this more appropriately meets their needs.

Response time and days/hours of operation

The Provider will respond to the needs of individuals and will deliver a range of services across 7 days in order to deliver the outcomes (refer to sub-specifications below).

Responses times are as follows:

- Referrals will be acknowledged within a maximum of 1 working day
- Triage will be available 7 days a week 365 days a year where appropriate.
- >95% of Acute referrals (following triage) will be assessed within 4 working hours
- > 90% of Urgent referrals (following triage) will be assessed within 3 working days
- >85% of Routine referrals (following triage) will be assessed within 30 working days
- There may be specific services which demand a different response time due to national or strategic objectives. Please refer to the sub specifications below.
- Assessments will take place face-to-face unless specified in the sub-specification that it can be via the telephone.

The service will deliver:

- Routine late afternoon/evening and weekend provision where there is patients/citizens demand.
- Rapid response wherever appropriate to meet individual needs
- End of life support available 24 hours a day, 7 days a week, 365 days a year (refer to sub-specification below).
- The service Provider must ensure that other activity delivered by the Provider (i.e. commissioned by other organisations/agencies) does not have a negative impact on capacity to deliver the service commissioned under this specification.

Multi-disciplinary, multi-agency assessment

- Integrated assessment will be undertaken for patients/citizens who may require input from a range of disciplines/agencies and assessment will be carried out by multi-skilled professionals.
- An appropriate holistic assessment will be undertaken, informed by information gathered at triage.
- Face-to-face assessment will be prioritised based on clinical need.
- Assessment will be carried out in conjunction with the multi-agency team wherever possible and the Provider will be expected to pro-actively facilitate this.
- Interdependencies and links with community and acute services will be key to the effective delivery of the service, including assessment, treatment and review.
- The views and needs of the patients/citizens and their carers will be at the heart of assessment.
- Assessment will be needs driven and not dependent on receipt of a specific clinical ‘diagnosis’.
- The emotional and mental health of the patients/citizens and their carer will be considered across the pathway.
- Referrals may be made to other agencies and services with appropriate consent.

Care co-ordination/ key-working

The overall aim of this activity is to provide information, advice, advocacy and support and co-ordinate the provision of holistic care and support to meet the individual needs of the patients/citizens (refer to the Sub specification Access, Navigation and Self-care).

Roles and responsibilities will include but are not limited to:

- Reducing or streamlining multiple appointments or contacts with acute health services, community (including GPs) and social care services and third sector services regarding changing needs or interventions.
- Communication and information sharing with acute health services, community (including GPs) and social care services, and third sector services, in line with the

principle to ensure information is gathered once and shared appropriately.
- Reviewing the amount of repeat 'did not attend' (DNAs) that occur within the service by working with patients/citizens to understand why these occur and the additional support or adjustments that could be put in place to minimise these.
- Joining up multi-agency assessments, planning and reviews wherever possible.

Carers

The Provider will be expected to identify patients/citizens who are informal carers e.g. unpaid, and refer them to the carers hub. This is to ensure that the carer and the person they care for are supported appropriately. The Provider will also be expected to promote the carers hub service to other statutory organisations including the acute sector, adult social care, community services, GP Practices and mental health to ensure that all carers are referred through to the hub.

The Provider will be responsible for raising awareness of carers and their needs within their organisation and ensure that all staff have the acquired knowledge to identify carers or cared for patients/citizens in a health or social care setting.

The Provider will also be expected to develop integrated joint care plans which consider the needs of the carer and the cared for person to prevent duplication of work. The Provider will be expected to have an understanding of what the carers hub offers in order to encourage carers to access the services available and work towards having a carers champion in all health and social care settings.

Personalised care planning

- A personalised care plan will be developed in conjunction with the patients/citizens, informed by the assessment, including assessment of risk.
- The care plan will ensure the needs and preferences of the patients/citizens and their carers are at the centre of care planning using 'support planning' principles.
- The care plan will use best practice and evidence based interventions including use of validated evidence based approach/tools to assess, identify and agree individual outcomes.
- The care plan will include clear outcomes using 'goal setting' principles, based on evidence based tools.
- The care plan will be available to share electronically, with appropriate safeguards and compliance with information governance requirements.
- The care plan will be shared with appropriate professionals.
- There will be a named worker for each patients/citizens available to contribute to multi-agency planning and review.

Personalisation

Providers will be required to work with the CCG in order to implement Integrated Personal Commissioning and offer Personal Health Budgets (PHBs) and Integrated Personal Budgets (IPBs) to service users/carers which will involve:

- Assisting in the identification of particular cohorts who are to be offered a PHB and/or Personal Budget (PB) for social care and/or an IPB.
- Working with the CCG to identify how relevant funding can be used for PHBs, PBs and IPBs and to release relevant funding back to the CCG as PHBs for individual service users/carers start to be implemented.
- Working with the CCG to agree roll-out and timescale for uptake of PHBs, PBs and IPBs to service users/carers from particular care groups. This will include, but not limited to, people eligible for NHS Continuing Healthcare and children eligible for

continuing care, people with multiple long-term conditions, people with mental health needs, people with learning disabilities and people receiving end of life care.

- Setting out how PHBs, PBs and IPBs will be aligned to ensure a seamless offer to service users/carers.
- Supporting service users/carers through the care and support planning process to identify and choose services and treatments that are more suitable for them, including services and treatments from non-NHS Providers – in line with implementation of the CCG's local offer.
- Providing appropriate services where service users/carers will opt to spend some or all of their PHB with the Provider.

Care delivery

Interventions will be delivered by a multi-disciplinary workforce with multi-skilled individuals in order to use resources as effectively as possible and avoid multiple contacts for patients/citizens and their carers.

Integrated or coordinated interventions will be delivered for individuals who may require input from a range of clinical disciplines, as detailed in the sub-specifications.

Care delivery will aim to minimise disruption to the lives of the patients/citizens and their carers and will be culturally sensitive. Care delivered will be flexible to respond to the emerging or changing needs of the individual and to have minimal disruptive impact on access to employment, social and family activities.

Provision of recommended equipment will be via the Nottinghamshire Integrated Community Equipment Loans Service (ICELS), Nottinghamshire Care Homes Equipment Policy, adult's and children's continuing care and/or wheelchair services.

Equipment

The Provider will be responsible for the management of the NHS Nottingham City CCG Integrated Community Equipment Loans Service (ICELS) budget.

The health funding will remain within the CCG but the ongoing shadow management of the budget and financial risk will move to the Provider.

The Provider will be expected to:

- Comply with the ICELS Nottingham City and Nottinghamshire County Policy for the Loan of Equipment into Registered Care Homes and Adults and Older People (March 2014) and any future amendments to the policy
- Comply with the Tissue Viability equipment pathway to support pressure care needs by assessing and reviewing equipment and stepping down equipment provision where appropriate
- Proactively plan and order equipment, working with the acute trust to anticipate discharges and actively reduce inappropriate same day and next day orders
- Attend and engage with the Operations Management Group to ensure adequate awareness of issues, best practice and policy
- Maintain communication with ICELS with regards to any service developments or service changes that may affect access to equipment with sufficient notice to plan and mitigate risks
- Support the testing of and research into new equipment and brands in order to continually meet the needs of patients/citizens and ensure value for money
- Analyse the frequent reports from ICELS in relation to equipment usage and prescriber lists and take necessary action and lessons learned from issues identified
- Ensure new staff are trained in a timely manner and have appropriate access to

equipment ordering
- Work with the ICELS team to ensure regular review of patients/citizens equipment needs to support the timely return of equipment no longer in use or required
- Take reasonable steps during domiciliary visits to identify unused/no longer needed equipment and arrange its prompt return to ICELS
- Take reasonable steps to review equipment provision in the home to ensure that they continue to meet the patients/citizens needs and are not over and above what is required

The Provider will be asked to review the spend against budget on a monthly basis and forecast spend based on actual activity. Any overspend on the planned budget based on inappropriate use of the service; outside of the above requirements, will be the Provider's risk and responsibility to fund. Where there is any overspend on the planned budget based on appropriate use of the service, this will be subject to discussion with the Commissioner. Any saving on the planned budget based on appropriate use of the service and improved equipment return rates will be credited to the Provider.

High dependency budget

This budget has approval for relatively low cost equipment to meet the needs of people with a high dependency care need that had previously had to be approved by the Continuing Care Panel.

For this reason the main eligibility criteria are:-
- That a clinical need has been established
- The need cannot be met by a prescription
- The patients/citizens has a high dependency care need

The system is set up to agree orders for relatively high volume, relatively low cost equipment, often consumables or equipment with a limited lifespan. Frequently ordered items include suction catheters and equipment for people who have had a tracheotomy.

The Provider will be responsible for the High Dependency budget and funding is allocated within the financial envelope of the contract. The Provider will have to work with GP Practices and Community nurses who are the main budget users.

The Provider must monitor activity and spend against this budget so that the Medicines Management Team within the CCG can assess the appropriate use of the funds.

Prescribing/medicines management

The Provider will need to develop local policies and procedures to ensure that medicines are handled safely, securely and in accordance with the legislation, professional standards and best practice guidance that applies to their activities.

Providers will have a formal arrangement in place for access to pharmaceutical advice to ensure there are robust governance processes in place for medication management and to support them in achieving these standards.

Prescribing advice may only be given by a pharmacy professional or prescriber and will be in line with national or local Nottinghamshire Area Prescribing Committee policies and guidelines and will comply with Nottinghamshire Joint Formulary status. Advice provided by other healthcare professionals e.g. pharmacists, nurse practitioners, nurses, dieticians, physiotherapists and others must be within agreed guidelines and any recommendations to patients/citizens or other clinicians that may affect prescribing should be within these parameters.
The Provider will be required to demonstrate that they comply with current legislation and NHS regulations regarding medicines.

Providers will be expected to comply with relevant sections of the Nottinghamshire Area Prescribing Committee 'Prescribing Policy between Nottinghamshire Commissioning Organisations and local NHS Service Providers'.

Any associated medicines costs are expected to be part of the service provision unless explicitly stated otherwise in the service specification. Provider organisations holding a prescribing budget will be expected to submit regular budget monitoring information and demonstrate compliance with local standards.

The Provider will ensure that all patients/citizens, where relevant, are assessed for medicine compliance to ensure that patients/citizens, including the frail elderly and those at risk of (re) admission to acute care are not detrimentally affected by side effects and that patients/citizens are supported to take medicines correctly and in a timely manner.

Mental Health

The Provider must build and sustain effective working partnerships with locally commissioned mental health Providers and other relevant organisations which promote positive mental health and wellbeing. By working closely with mental health partners, an integrated delivery model is expected so that the 'Out of Hospital' contract facilitates:

- Earlier promotion and identification of mental wellbeing
- A preventative and self-care approach to managing mental health across Nottingham City
- Increased access to mental health services through successful partnership working (including with primary care based mental health and wellbeing support services, Improving Access to Pyschological Therapies (IAPT), Primary Care Mental Health Service and secondary/specialist mental health teams)
- Delivery of integrated physical and mental healthcare, including 'integrated IAPT'
- Improvements in the quality of life for people with mental health problems
- A holistic approach to the development of individual care plans, recognising that mental health and physical health are intrinsically linked

By delivering more integrated models of care, the Provider will play a vital role in helping the CCG achieve various recommendations included in "The Five Year Forward View for Mental Health". It will also create a culture to support 'Parity of Esteem', placing equal value on both mental and physical health.

Integrated IAPT

As well as adopting the more general approach described above, the Out of Hospital contract is pivotal in helping delivery of 'Integrated IAPT' as outlined in 'The Five Year Forward View for Mental Health'.

By working in partnership with local IAPT services, the Provider will help increase access to psychological therapies by developing integrated care pathways for people with common mental health disorders (e.g. depression or anxiety disorders). Building on the learning and experience of Nottingham City CCG as an Early Implementer site, the Provider will seek additional opportunities to deliver integrated IAPT. This requires development of pathways which acknowledge the common principles of core IAPT outlined in NHSE/NICE's Interim Guide for Integrated Care and Psychological Therapies for Mental and Physical Health but which would also see the Out of Hospital Provider undertaking joint working with IAPT partners to develop, where possible:

- **Integrated care pathways**: integrated IAPT staff should be co-located with the physical health care teams; integrated working includes joint team meetings, care

planning and, where necessary, joint working.

- **Case recognition methods in physical health care**: all LTCs or Medically Unexplained Symptom pathways, which involve an integrated IAPT service, should have mental health case recognition tools in routine use.
- **Closer links with core IAPT services**: allowing sharing of best practice, integrated IAPT and core IAPT services may have shared personnel and shared management, training and supervision arrangements, which will may also contribute to reduce costs.

Managing Complexity

The kind of care and where it is provided should be determined by the nature and complexity of a person's presenting needs at that time. The greater the level of complexity of the presenting issues, the more substantial and multi-professional the package of care needs to be, considering factors such as:

- Nature, severity, chronicity and prognosis of the physical health problem
- Complexity of the physical health interventions delivered and the settings in which they are provided
- Nature, severity, chronicity and prognosis of any mental health problems
- Significant drug and alcohol misuse
- Degree of cognitive and/or functional impairment or disability
- Social and environmental factors that influence access to or delivery of care

The Out of Hospital Care Provider is expected to deliver services in a way which takes account of complexity. This will mean being able to deliver both uni-professional models of care (where lower complexity) and multi-professional interventions (where higher complexity). Effective multi-disciplinary planning and case management will be essential.

ReSPECT – Recommended Summary Plan for Emergency Care and Treatment

The Resuscitation Council UK have released the ReSPECT process and form. The ReSPECT process creates individualised recommendations for a person's clinical care in emergency situations, including cardiorespiratory arrest, in which they are not able to decide for themselves or communicate their wishes.

ReSPECT aims to encourage patients/citizens and family involvement in decision-making, to consider recommendations about CPR in the context of broader plans for emergency care and treatment, and to record the resulting recommendations on a form that would be used and recognised by health and care professionals across the UK.

The ReSPECT form is completed through conversations between the person and one or more of the health professionals who are involved with their care. Professionals such as ambulance crews, out-of-hours doctors, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to agreed clinical recommendations on a ReSPECT form. It is intended that the ReSPECT form will replace the 'standalone' DNACPR form. (Please refer to Documents Relied On – Schedule 5)

The Provider is expected to utilize the ReSPECT form in delivery of the service.

Electronic Palliative Care Co-ordination Systems (EPaCCS)

Electronic Palliative Care Co-ordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about end of life care.

The Provider is expected to have Nottinghamshire EPaCCS compatibility and work with GP Practices to ensure that all appropriate patients/citizens are entered onto the system and managed accordingly.

Transfer of Care (facilitated discharge and avoiding admission)

Advice and clinical interventions will be provided to patients/citizens, carers, acute and community health services and professionals with the aim of:

- Facilitating clinically appropriate discharge from acute services
- Avoiding unnecessary admission or attendance at Emergency Department (ED)
- Providing continuity of care

The Provider will develop care pathways to facilitate this, including working collaboratively with acute services to develop in-reach working to streamline handover of care to community services. This will include flexibility to deliver intensive interventions in the community to support step-down from acute services or prevent an avoidable admission, and the delivery of in-reach support to ensure delivery of interventions during hospital admissions.

The service will identify patients/citizens that have repeat, or inappropriate, attendances at ED or admissions to acute services and deliver appropriate interventions and support to minimise these.

The service will establish strong relationships with General Practice. This will include provision of linked/named staff for each GP practice to ensure that GPs are supported and well informed about a patients/citizens health needs and care. This will include providing support where there may be concerns, or risk of acute exacerbation. This will be integrated within the care delivery group models. The service will work with primary care professionals to develop their knowledge and skills.

Review/Follow up

Review/follow up will be undertaken when clinically appropriate to ensure that care provision for patients/citizens continues to meet their needs.

Discharge

Where a patients/citizens care is complete, or their needs change to the point that this contract can no longer support them, the patients/citizens will be discharged, or onwardly referred to other more appropriate services such as third sector, social care or acute care. Clear reasons for discharge will be discussed and communicated with the individual and their carer, and information shared with the GP, the referrer and other appropriate professionals.

Processes/pathways will be in place to enable fast track access to the Integrated Out of Hospital contract should needs re-occur.

In order to support the safe transition of care from hospital to the community, electronic discharge processes will be in place. These must conform to the NHS England core Provider contract requirements.

Does Not Attend rates (DNA)

The Provider will be expected to develop a policy to maintain or reduce expected low numbers of DNAs which may include the following:

• Confirmation of contact details at the point of referral
• Confirmation appointment letters

• Text message reminders

Patients/citizens engagement and participation

Patient engagement and participation will be embedded in service delivery, design and improvement through co-production with patients/citizens. The Provider will ensure that continual review and evaluation of the service via effective two-way engagement with the patients/citizens and their carer is embedded in the care delivery.

At all stages the Provider will ensure communications about assessment and treatment are clear and timely and that the patients/citizens and their carer have opportunity to feedback.

Information management and technology

All Nottinghamshire Health and Care Providers are members of the Connected Nottinghamshire Programme of work (as part of the Nottinghamshire STP). The Provider will be expected to be part of this Programme and to support the development and delivery of the Nottinghamshire Local Digital Roadmap (http://www.connectednottinghamshire.nhs.uk/news/communications/connected-nottinghamshire-health-and-care-local-digital-roadmap/) and the Nottinghamshire CCG IGM&T Strategy (http://www.rushcliffeccg.nhs.uk/media/4135/17079-igmt-strategy-v44.pdf) ambitions and milestones.

- Information management and technology (IMT) systems will support the principle that core information about patients/citizens will be recorded once and shared appropriately, supported by relevant levels of consent and choice, delivered in line with Nottinghamshire information governance policy and the safeguarding board guidelines. This will mean that the Provider will have to have systems that are able to support the following:Shared or integrated electronic care records with access for all appropriate professionals including GPs.
- Access to a shared electronic care plan for the patients/citizens and their carer, which is centred around their needs and enables them to communicate information with the service.
- Mobile access with appropriate security and information management safeguards.
- Use of appropriate assistive technology to offer support and flexibility in the care delivered.
- Innovative use of technology to support improved contact and support e.g. teleconsultation.
- Compliance with local data quality principles and membership of the Nottinghamshire Data Leadership Alliance (if not already a member)
- Compliance with relevant Information Governance, confidentiality and consent standards.

Workforce

The workforce must have sufficient capacity, skills knowledge and behaviours in order to effectively deliver the service to meets the needs of the local population and achieve the outcomes identified. The Provider will have a clear workforce development plan covering the whole workforce to demonstrate how the following will be achieved:

- Discipline specific professionals with specialist levels of skill to undertake triage, assessment, care planning, interventions and management/supervision of multi-skilled colleagues
- Multi-skilled professionals and support workers/skilled carers, to support delivery of multi-disciplinary interventions

- Administration and data management support
- Staff with specialist communication skills
- Staff with skills in peer support, key working, care co-ordination or advocacy
- Staff with appropriate skills in medicines management/prescribing
- Staff with skills to promote self-care and self-management linking to Personalisaton and 'Making every Contact Count'
- How Social Value can be met through staff initiatives and support such as mobile working, sustainable travel, smoking cessation, healthy lifestyles etc

Development of the workforce will respond to the opportunities to develop new roles across traditional boundaries, recognising skills and competencies which require a specific professional registration and those which could be shared and developed across professional boundaries.

The Provider will ensure that the workforce have the equipment and supplies to undertake their roles.

For all services in the core specification the Lead Provider (and all sub-contractors) will meet the following Workforce and Training Standards:

•All staff involved in the delivery of the service specifications will be competent, adequately trained and have had a Disclosure and Barring Service Checks as determined by the Provider.

•All qualified staff will be registered on the appropriate professional register and be legally able to practice

•Statutory training (that which an organisation is legally required to provide as defined by law where a statutory body has instructed organisations to provide training on the basis of legislation) will be provided as necessary and a target of 90% compliance expected.

•Mandatory training (that determined essential by an organisation) will be prioritised and provided for all staff and a target of 90% compliance expected.

•Appraisals (a process for an individual employee and their Line manager(s) to discuss their performance and development, as well as the support they need in their role) will be available to all staff on an annual basis with a target of 90% compliance expected. Each member of staff will have a structured appraisal/PDP (Personal Development Plan) process which will include discussion of clinical and operational performance. The PDP process will include organisational, individual and clinical objectives.

The Provider must ensure that have a workforce strategy and the Provider must implement a comprehensive induction programme for all staff that supports their workforce strategy and the delivery of the service.

•Sickness absence (defined as an employee or their GP considering themselves unfit to attend work due to minor ailments, major illness of sudden onset, or an ongoing chronic disease or accident. Sickness absence can also be planned in cases where the employee requires surgery or a medical procedure) The average sickness absence (recorded as a % of contracted WTE (whole time equivalent) due to sickness) rate for the NHS up until December 2016 is 4.4% of the workforce off work due to sickness absence reasons at any one point in time. A target rate of <3.5% will be expected.

•Turnover (the number of percentage of workers who leave an organisation and are replaced by new employees) will be measured to identify and examine reasons for turnover. (awaiting figures for national Turnover) A target of < (or equal to) 9.9% compliance expected.

•All staff will benefit from a clear Health and Wellbeing strategy that will promote the reduction of sickness and turnover and will enhance working conditions.

Training provision

The Provider will develop and deliver comprehensive training packages to ensure that the wider workforce have the skills and competency to meet the needs of patients/citizens. Training may be delivered to individuals or groups.

Pathways will be established to other established training such as diabetes and asthma.

Infection, Prevention and Control

Provide specialist advice and support to all patients/citizens registered with a Nottingham City GP including their carers and relatives and all staff within the organisation.
The Provider will be fully compliant with all infection prevention and control legislation
All community patients/citizens and relevant care home residents in homes with nursing beds registered with a Nottingham City GP will have any infection promptly identified, be appropriately managed/followed up and have easy access to support and information, including those discharged from acute care
All risks of infection will be minimised by the Provider's staff adhering to the principles of infection prevention and control
All staff will have easy access to relevant information and fully implement infection prevention and control policies
All outbreaks of infection will be promptly identified, recorded locally through to outcome, managed appropriately and reported to the relevant authorities in a timely manner
All healthcare associated infection related serious incidents (SIs) will be promptly investigated in line with national guidance
Quality assurance and compliance will be evidenced by infection prevention and control related audits
Annual programme of work will be in line with national and local guidance, priorities and nationally set healthcare associated infection limits assigned to NHS Nottingham City Clinical Commissioning Group
An effective infection prevention and control staff training programme will be implemented
Work with the local health economy to pro-actively reduce the impact and transmission on Norovirus / gastro-enteritis type outbreaks by providing clinicians and the general public with appropriate and effective information and advice.

Tissue Viability

The Provider will deliver specialist wound care advice for the assessment and management of any patients/citizens with healing problems registered with a Nottingham City General Practitioner.

Tissue Viability will also provide specialist wound care therapies and advice to patients/citizens and the staff caring for them on an individual basis to promote wound healing and prevent deterioration or recurrence.

The objectives of the Tissue Viability Service include:

- To reduce the overall incidence of pressure ulcers and prevent an increase of pressure ulcer development
- To lead, promote and standardise optimum levels of care for patients/citizens to promote healing and improve quality of life
- To increase the healing rates and improve the management of wounds affecting the lower limb / foot and reduce recurrence rates
- To reduce clinical risk, by advising organisations on safeguarding issues and the investigation of incidents and complaints relating to Tissue Viability

- To improve services for patients/citizens by acting as an advocate, liaising between all services within the care setting
- To reduce preventable hospital admissions
- Increase early discharge from acute services into primary care for patients/citizens with complex wounds -promoting continuity of care in the community
- To provide a leg ulcer clinic service. This should include Leg Ulcer Clinic Coordinators meeting bi-monthly for service and clinical development.
- To complete specialist equipment assessments for patients/citizens requiring pressure relieving equipment via the Integrated Community Equipment Store. This shall include Continuing Care assessments for pressure relieving equipment, including reviewing patients/citizens as necessary.
- To advise pharmacies and supplies departments regarding the acquisition and management of wound care products.
- To provide professional advice regarding the investigation of complaints, incidents and safeguarding involving Tissue Viability related issues. To work with the systems team to develop a system to support pressure ulcer incidence data collection.
- To undertake quality assurance of all route cause analysis conducted on stage III and IV incidents of pressure ulcer development.
- To be responsible for the development, implementation and regular review policies, protocols, formularies, documentation and guidelines.
- To be responsible for providing training to trained/registered community and General Practice staff on the following topics;
  - Pressure Ulcer Prevention
  - Wound Management
  - Leg Ulcer Management
  - Advanced Tissue Viability
  - Compression bandaging
  - Doppler ultrasound
- To be responsible for providing the following training to support/ healthcare assistant staff:
  - Tissue Viability
  - Advanced Tissue Viability for HCAs

Prior to referral all wounds must be assessed and a plan of care implemented in accordance with the Wound Care Formulary and Wound Management Guidelines, Leg Ulcer Guidelines and the Pressure Ulcer Prevention and Management Guidelines - Tissue Viability Link Nurses should be used as an initial resource for advice.

The criteria for referral includes:

- Patients/citizens with a wound care plan which is failing to be effective and the wound is static or deteriorating.
- Patients/citizens registered with a Nottingham City General Practitioner
- Patients/citizens of any age

Interpreting and translation

The Provider will offer a comprehensive and effective Interpreting and Translating Service to ensure equity of access to the commissioned services within this contract for those whose first language is not English; and blind patients/citizens registered with a GP within Nottingham City (and south county CCGs for STOC front door and Continuing HealthCare). The service will help to improve communication and avoid where possible, the need to rely on family members and friends for interpreting through the provision of face-to-face interpretation, the use of the telephone interpreting service Language Line and/or supporting healthcare colleagues to translate information into accessible formats.

The Provider will:

- Provide an accurate and confidential interpreting and translation service that adheres to

the four Principles of the Interpreters Professional Code of Conduct – Honesty and Integrity, Professional Competence, Client Confidentiality and Trust, and Relationships with other members and to comply with the Interpreting Service standards for quality of interpretation.

- Demonstrate that interpreters are trained to work with healthcare professionals around breaking significant news to patients/citizens
- Ability to evidence that interpreters have received training specifically around medical terminology and understand how to translate probing questions and in a culturally acceptable manor
- Encourage patients/citizens to ask questions and be able to make an informed choice regarding their treatment
- Ensure the understanding of the nature of the health problem, the purpose and the type of treatment
- Have awareness of cultural attitudes and beliefs that may exist and which will influence the acceptability and appropriateness of care, whilst being sensitive and respectful to the patients/citizens.
- Refer patients/citizens to the Nottinghamshire Deaf Society for requests for deaf interpretor appointments. The CCG has a separate contract and funding for this provision.

Assistive Technology

Assistive Technology is the broad term to describe equipment and service which can enable independence for disabled and older people. This includes Telecare – equipment to help vulnerable people live safely and independently in their own home, Telehealth – equipment for the remote monitoring of patients/citizens with long term conditions, and Telemedicine – video conferencing for virtual clinics and diagnosis. In Nottingham the delivery of Assistive Technology has been nationally recognised and there is good evidence that the use of Assistive Technology cannot only support patients/citizens but also achieve service delivery savings through avoided emergency hospital admissions, A&E attendances and avoided unnecessary nurse visits.

The Community Health Provider will need to utilise Assistive Technology services in supporting patients/citizens who use those services. This will either be direct use of Assistive Technology to help manage the presenting condition of the patients/citizens or referral into the Service for an assessment of equipment to meet wider needs. The Provider will be expected to work with the Assistive Technology Service in helping to raise awareness amongst the workforce of Assistive Technology and to maintain this knowledge. The Provider will also be expected to work with the Assistive Technology Service in embedding Assistive Technology into service pathways and in developing new Assistive Technology solutions to meet citizen and service needs.

Information Governance

Information Governance (IG) is important to ensure that personal or personal sensitive data is handled in a secure and confidential manner. IG ensures safeguards for and appropriate use of information and it provides a framework to ensure that such information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Ensuring that the organisation and all staff are suitably equipped to manage this important area of work is a key priority for providing high quality and effective health and social care services. The IG Toolkit provides an assessment framework for organisations to demonstrate how they are meeting confidentiality and data protection, information security, clinical and corporate records management, data quality and secondary use assurance requirements.

IG should be embedded in all systems, processes, polices and staff training. The

consequences of not meeting IG standards could result in loss of trust and confidence from patients/citizens (in cases of a data breach) and reputational damage to the organisation and wider NHS. Demonstration of meeting IG standards and capability is a fundamental area in the successful delivery of services to patients or citizens.

Service Review

The Provider is required to prepare for and participate in regular service reviews. Service Reviews will focus on whether the outcomes of the service specification are being met and should consider activity, performance and quality issues such as Serious Incidents, complaints, patients/citizens feedback. A review of the Equality Impact Assessment action plans where relevant should be assessed whether the recommendations have been implemented or progressed.

Any items for escalation, areas of concern or areas of good practice should be shared with the contract team at the next contract meeting to allow for additional support to progress developments or acknowledgement of the improvements already made.

NHS Nottingham City CCG has a standard agenda format to ensure that there is consistency across the Service Review Meetings.

The decision to undertake a quality visit will be based on (but not limited to) information obtained from the service review process, incident and serious incident reporting, financial recovery, patients/citizens experience and CCG specialists. This data will assist in identifying services that require a visit due to the concerns identified rather than visiting all services commissioned. Unannounced quality visits may be undertaken.

Research

The Provider should:

- Develop an Organisational culture where research, evaluation, clinical audit, and quality improvement initiatives are proactively supported to ensure the continual improvement of patients/citizens care, health outcomes and the effectiveness of health services
- Develop a Board approved Research Strategy or approach (with a live implementation plan) which includes a description of how the organisation will engage with researchers, patients/citizens, service users and carers in the development of new research studies
- Proactively engage with the National Institute for Health Research Clinical Research Network East Midlands (NIHR CRN EM) to participate in the delivery of NIHR portfolio research studies to ensure that patients/citizens are given the opportunity to participate in research studies when available and appropriate to them
- Support research capacity and capability initiatives for the workforce including supporting staff to apply for Health Education England (East Midlands) Bronze, Silver and Gold Clinical Scholar Awards and National Institute for Health Research fully funded Masters in Clinical Research and PhD fellowships

3.3 Population covered

The Provider will offer a service to any patients/citizens registered with a GP within Nottingham City.

The Provider will also offer a service to the patients/citizens registered in NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG for the function of STOC (supported transfer of care) Front Door (refer to the Integrated Care specification) and Continuting Care, Funded Nursing Care and Section 117 for adults and children (refer to Continuing Care specification).

3.4 Any acceptance and exclusion criteria and thresholds

Refer to the individual sub-specifications below

3.5 Interdependence with other services/Providers

- Acute Providers
- Other community services
- Nottingham City Local Authority (including Adult Social Care Services, Crime and Drugs Partnership and Public Health Departments)
- Nottinghamshire County Local Authority (including Adult Social Care Services and Public Health Departments)
- Out of Hours Providers (NEMS, 111)
- Mental Health Providers (Nottinghamshire Healthcare NHS Foundation Trust, Framework, Primary Care Psychological Therapy Providers
- Primary Care (GP Practices)
- Emergency Services (EMAS)
- Patients Transport Services
- Third sector Providers
- Employment services
- Education Providers/Colleges/Univesities/Training Providers
- Police
- Fire Service
- NHS England
- Care Delivery Groups (which include the following staff groups Primary Care, Community Services and the Local Authority)
- Nottingham Health and Care Point
- IAPT (Primary Care Psychological Therapy Providers)
- Primary Care Mental Health and Wellbeing Support Services
- Patients/citizens Support Groups / Condition Specific Support Groups
- Housing Providers and Housing Aid
- Healthy Working Futures (Health and Employment Service)
- Financial Advice Services
- LiON Directory https://www.asklion.co.uk/kb5/nottingham/directory/home.page
- Healthwatch Nottingham
- Any other relevant organisation

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

– National Institute for Clinical Excellence (2005) Pressure Ulcer Prevention and Treatment Guidelines
– The Prevention and Treatment of Pressure Ulcers NICE Clinical Guideline 29 NICE 2005
– The use of pressure relieving devices (beds, mattresses and overlays) for the prevention of pressure ulcers in primary and secondary care, NICE October 2003
– Guidance on the use of debriding agents and specialist wound care clinics for difficult to heal surgical wounds, NICE 2001
– Compliance with the CQUIN target to reduce the occurrence of pressure ulcers in the community by 0.3% per quarter in 2010/11
– Pressure Ulcer Prevention and Treatment Guidelines, European Pressure Ulcer Advisory Panel &National Pressure Ulcer Advisory Panel 2009
– High Impact Actions For Nurses 2010. DoH
– Surgical Site Infection NICE Clinical Guideline 74 (2008)
– The NHS Constitution
– Equality Act 2010

- Health and Social Care Act 2012
- Human Rights Act (1998)
- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
- United Nations Convention on the Rights of the Child (1989)
- The Accessible Information Standard 2015
- UN Convention on the Rights of Persons with Disabilities 2005
- Data Protection Act 2003
- NICE Clinical Guidelines for diabetes and other conditions/diagnoses https://www.nice.org.uk
- Institute for Health and Clinical Excellence (NICE) Clinical Guideline: Osteoporosis fragility fracture, 2012 (CG146), Falls: The assessment and prevention of falls in older people, 2004 (CG21)
- NICE Guidelines (Parkinson's disease and Multiple Sclerosis)
- National Accelerated Stroke Programme
- National Clinical Guidelines for Stroke (2016)
- NICE guidelines for Stroke (2017)
- NICE Improving Supportive and Palliative Care for Adults with Cancer (2004)
- SIGN Cardiac Rehabilitation (2002)
- SIGN Heart Failure (2007)
- ACPICR Standards for Physical Activity and Exercise (2009)
- NICE Cardiac Rehabilitation (2011)
- NICE Heart Failure (2011)
- Cardiovascular Disease Prevention and Rehabilitation (BACPR 2012)
- NICE (2011) Quality standards for end of life care for adults
- Area Prescribing Committee (APC Local Guidelines)
- NICE CG10 (2004) Type II Diabetes Prevention and Management of Foot Problems
- NICE CG21 (2004) The Assessment and Prevention of Falls in Older People
- Society of Chiropodists and Podiatrists Minimum Standards for Practice
- Society of Chiropodists and Podiatrists Faculty of Podiatric Surgery Standards
- Trent and South Yorkshire Patients Satisfaction Audit – Core Podiatry, Nail Surgery and Biomechanics (2007)
- Department of Health (2000): Good Practice in Continence Services. Department of Health, London
- An integrated continence service in line with the National Service Framework (NSF) for Older People
- The Health Act (DH, 2012)
- Saving Lives – High Impact Intervention 6 (DH, 2008)
- NICE Guidelines on female incontinence (2006)
- 18 week referral to treatment target (NHS Improvement Plan, June 2004)
- Care closer to home (DH 2008)
- NICE guidance CG97 Male Lower Urinary Tract Symptoms (LUTS) (May 2010)
- Coronary Heart Disease National Service Framework (NSF) (2000)
- Our Health, Our Care, Our Say (2006)
- NICE Obesity Guidelines (2006)
- Tackling Obesity: Future Choices, Foresight Report (2007)
- Healthy Weight, Healthy Lives: Cross Government Strategy (2008)
- NICE Guidance: The Management of Type 2 Diabetes (2008)
- NICE Guidance: Improving the Nutrition of Pregnant and Breastfeeding Mothers and Children in Low Income Households (2008)
- https://www.resus.org.uk/respect/ - Recommended Summary Plan for Emergency Care and Treatment
- NICE Mental wellbeing and independence for older people (Quality Standard QS137)
- NICE Mental wellbeing in over 65s: occupational therapy and physical activity interventions (Public Health Guideline PH16)
- NICE Older people: independence and mental wellbeing (NICE Guideline NG32)
- National Service Framework for Older People (DH 2001)
- National Service Framework for Diabetes (DH 2001)

- NICE CG10 (2004) Type II Diabetes Prevention and Management of Foot Problems
- NICE CG21 (2004) The Assessment and Prevention of Falls in Older People
- Society of Chiropodists and Podiatrists Minimum Standards for Practice
- Society of Chiropodists and Podiatrists Faculty of Podiatric Surgery Standards
- Health Professions Council Standards
- Essence of Care
- Standards for Better Health
- Our NHS, Our Future – NHS Next Stage Review (DH 2008)
- Trent and South Yorkshire Patients Satisfaction Audit – Core Podiatry, Nail Surgery and Biomechanics (2007)
- N2098 - Surgical correction of hallux valgus using minimal access techniques
- Obesity (CG43)
- Diabetes Foot care (CG10)
- Type 1 Diabetes – Education (CG15)
- Diabetes (type 1 and 2) patients education models (TA60)
- Diabetes (type 2) Management of T2 Diabetes (update) (CG66)
- Medicines Management (CG76)
- Infection Control (CG2)
- Surgical Site Infection (CG74)
- Pressure reliving devices (CG7)
- Inadvertent perioperative hypothermia (CG65)
- Workplace interventions for smoking cessation (PH5)
- Smoking Cessation services (PH10)
- Brief interventions for smoking cessation (PH1)
- Human Medicines Regulations (2012)
- Controlled drugs (Supervision of management and use) regulations (2013)
- Misuse of Drugs Act (1971)
- Misuse of Drugs regulations (2001)
- Misuse of Drugs (safe custody) regulations (1973)
- The Health Act (2006)
- Health and Social Care Act (2008)
- The Equality Act (2010)
- European Community Directive (2001/83/EC)
- Environmental Agency T28 – sorting and denaturing controlled drugs for disposal
- Royal Pharmaceutical Society Medicines, Ethics and Practice
- Good Practice in Prescribing and management medicines and devices GMC 2013
- DH protocol for ordering, storing and handling vaccines
- Control of substances hazardous to health (COSHH) guidance
- Current good practice guidance issued by organisations including RPS, GPhC, MHRA, DoH, NICE, Home Office, NHS Patients Safety etc
- A guide to good practice in the management of controlled drugs in primary care (National Prescribing centre)
- CQC standards for medicines management outcome 9
- NICE Guidance (2004) Improving Supportive and Palliative Care for Adults with Cancer
- NICE (2011) Quality standards for end of life care for adults
- The Mandate – a mandate from the government to the NHS Commissioning Board: April 2013 to March 2015
- The NHS Constitution (8 March 2012, Department of Health)
- The NHS Outcomes Framework 2014/15 (Department of Health)
- Depart of Health End of Life Care Strategy
- NICE Quality Standards in End of Life (QS13)
- The Palliative Care Funding Review (June 2011)
- Any other relevant standards, including new publications, revisions and updates
- Addressing ambulance handover delays: Letter from Professor Keith Willett (page 4)

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

- Royal College of Nursing (2006) Leg Ulcer Assessment and Management

– Clinical Practice Guidelines Pressure ulcer risk assessment and prevention, Royal College of Nursing 2003

4.3 Applicable local standards

- Wound Care Product Formulary and Guidelines (2008). (APC)
- Emollient Guidelines (2009). (APC)
- The Nottinghamshire End of Life care pathway for all diagnosis (Nottingham City PCT)

5. Applicable quality requirements and CQUIN goals

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

Refer to Schedule 4A-D and Local Incentive Scheme Schedule 4E

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Refer to Schedule 4E

6. Location of Provider Premises

The Provider's Premises are located at:

Location of service delivery / Estates / Premises

Services will be based on the Care Delivery Group structure across the City and the Provider will ensure strong links with general practice in order to support appropriate use of GP services to avoid unnecessary ED attendances and hospital admissions.

Interventions will be delivered in a variety of locations across the City and at times to meet the needs and choice of patients/citizens and their carer. Locations will include but are not limited to:

- Patient's/Citizen's home
- Health centres
- Community clinics
- Residential/Nursing Homes
- Homeless shelters
- Other sites as applicable

We expect the Provider to maintain engagement and fully support the Primary Care Premises Group and development of any strategies. Where current utilisation is affected by any strategies we would expect you to have a flexible approach.

The Provider is anticipated to use the existing NHS premises currently utilised. Where Providers are not willing, or able, to use existing NHS estate, the cost of that estate must be covered within the published cost envelope.

Commissioners will need a clear understanding of why it is not possible to use existing NHS estate, particularly where services are currently delivered from NHS locations.

NHS Estate costs are is not included in the cost envelope. The Provider is informed that the current NHS estate will be funded by the commissioner as pass through cost via the provider to NHS Property Services or Community Health Partnerships (CHP).

Any additional premises, over and above what is currently used, will need to be paid for by the Provider.

Clinical discipline specific elements / sub-specifications of the Out of Hospital Community Services Contract

The following clinical discipline specific elements or 'sub-specifications' embedded within the Out of Hospital Community Service Contract will be delivered as an integrated service so that patients/citizens experience seamless provision and have their health needs met wherever they are.

Please note: The sub-specifications are not stand alone specifications. They form part of and should be read and used in conjunction with the Out of Hospital Community Service Contract specification above and accompanying appendices below.

Sub-specifications:
A Access, Navigation and Self-Care
B MOSAIC
C Long Term Conditions
D Integrated Care*
E Care Homes Nursing
F Continuing HealthCare
G Infection, prevention and Control (Independent Providers)
H Specialist Paediatric Services
I Homeless Health Team
J GP Interpreting and Translation
K PLT admin
L Property Support Services (TBC)

***** *including Supported Transfer of Care – Front Door provision across NHS Nottingham City CCG; NHS Nottingham North & East CCG; NHS Nottingham West CCG and NHS Rushcliffe CCG*
** including Integrated Urgent Care and Integrated Reablement service which is provided in partnership with Nottingham City Council.*

Service Specification: C
Long Term Conditions / Case Management

Please note: This is not a stand-alone specification. It forms part of and should be read and used in conjunction with the Out of Hospital Community Services core service specification, sub specifications and appendices.

Purpose of service

A Long Term Condition (LTC) is defined as patients/citizens diagnosed with a chronic disease which cannot be cured for example Frailty, Diabetes and Heart Failure but managed with medication and other forms of treatment. Case Management involves integrating services around the needs of individuals with Long Term Conditions (including mental health support when identified as needed). This will be a targeted, community-based and pro-active approach to care that involves case finding, assessment of patients/citizens, rehabilitation, care planning and care co-ordination.

The core purpose of Long Term Conditions and Case management involves improving the quality of life and experience for those at end of life, the elderly, at risk of hospital admission and all adults with long term conditions including their carer's. This will involve having a multi-disciplinary approach, supporting groups and individuals, providing education and promoting self-care in order for patients/citizens to be re-abled and to remain as independent and self-sufficient as possible within their own home/environment.

Aims and objectives

Self-Care management and independence

- Provide an equitable service for patients/citizens in the community with a long term condition prior to and from the point of diagnosis
- To support patients/citizens effectively to manage and make informative decisions about their own physical, mental health and care
- Provide access for patients/citizens and carers on advice, education and self-management
- To improve awareness of self-care and managing Long Term conditions in the population and within BAME communities and ensure that they are case managed appropriately
- To promote longevity to ensure that patients/citizens are able to live in the community for as long as possible and promote extended independence to live in the community and develop optimal self-care plans

Prevention

- Provide brief interventions such as smoking cessation (including in-reach smoking cessation to NUH acute wards), pulmonary rehab, exercise, improve Barthel or equivalent dependency score and weight loss (and other interventions long term condition specific)

Care Planning

- Promote and ensure patients/citizens have a well-co-ordinated care plan shared with GPs that enables them to live and die where they choose if deemed as at the end of their life

- Supporting a patient/citizen or carer and working to deliver their agreed/advanced care plan
- Supporting Primary Care to embed practices and policies of end of life care through GP Facilitator
- GP Facilitator to support the development of new clinical guidance for Primary Care and the Community.
- Lead and assist in the implementation and evaluation of ReSPECT process across Greater Nottingham
- Liaising and Supporting organisations (i.e. EMAS & NEMS) with the implementation of ReSPECT

Multi-Disciplinary working

- Implement an integrated model of care by delivering multi-disciplinary support from health and social care expertise to encourage shared decision making by all staff
- Ensure parity of esteem between physical and mental health – identify any comorbid mental health components which, if treated as part of an integrated model, could optimise physical health outcomes for patients/citizens
- Support and participate in multidisciplinary meetings with all practices aligned to their CDG.
- Following multidisciplinary meetings where patients/citizens with a need are identified, a case manager will be allocated and they will be responsible for the patient/citizens ongoing care and ensuring that the approach to the patient/citizens care is co-ordinated, documented and communicated.

Medicines Management

- Ensure services and pathways that include medicines are safe, deliver improved patient outcomes, offer patient choice, a good patient experience and provide clinically effective and cost effective treatment

Reduction in hospital and unplanned admissions

- Reduction in the following areas: unnecessary admissions to social care, avoidable hospital admissions or re-admissions, GP appointments, secondary care, support timely discharge from hospital and avoid excess length of stay and to offer an alternative to hospital admission and move care closer to home
- For all adults, patients/citizens to maintain independence who are at risk of hospital admission from a Long Term Condition or frailty including positive experience of End of Life care

Continued Support

- To ensure that carers/family members are identified in line with service criteria and supported appropriately
- To facilitate access and onward referral to other appropriate agencies (e.g. Social worker, Day Care, Hospice at Home)
- To provide In Reach support to Care homes for the following: Speech and Language Therapy, Stroke, Home Oxygen and End of Life Care

The Provider will include the following elements within the LTC/Case Management Pathway:

Prevention

- Strong emphasis on smoking cessation throughout the pathway (including in-reach smoking cessation to NUH acute wards) and providing brief interventions to support people to stop
- Good links to lifestyle services to support people in reducing weight
- Recognition that CVD (cardio vascular disease) is one of the main causes of death and disability in the UK, but it can often largely be prevented with a healthy lifestyle such as stopping smoking, a balanced diet and exercise – therefore good links to services is essential
- Working closely with pre-diabetes services for people who are at risk of diabetes

Long Term Conditions specific

Community Nursing

- Be expected to make direct links to acute nursing for those patients that are presenting with an acute, short-term nursing need e.g. post-operative advice and support those who are housebound by using a holistic approach that maximises the health potential of not only the patient but also addresses the wider health and social care needs of patients and their carers
- To support and advise citizens, carers and home care Providers to safely administer prescribed medication in the home including delivery of nursing interventions by appropriately training staff in the following areas to ensure consistent competency: Syringe pump medications, percutaneous endoscopic gastroscopy feeding, rectal insertion, transdermal medications, intramuscular and subcutaneous injections
- The Provider will also be expected to support the removal of breast drains in the community and training links within the acute sector should be arranged
- Align community nursing team to each Care Delivery Group (CDG)
- Ongoing case management shall be available to patients/citizens identified through the use of risk stratification tool/clinical judgement as part of the multidisciplinary approach to preventative care.
- Responsible for wound care management (including management of supplies) in the community which should include leg ulcers, pressure ulcers and other chronic acute wounds
- Provide seasonal pneumococcal and flu vaccinations to patients/citizens who are housebound and will work with commissioners to respond to seasonal vaccination plans as appropriate.
- Provide leg ulcer clinics and the provision of Doppler testing in the community
- Responsible for providing an holistic assessment of patient/citizens needs.

Continence

- Provide a Continence and Urology Outreach service that is evidence-based, holistic and individual to patient assessment, treatment and management for people who have bladder and/or bowel problems (including products and home delivery service)
- Assess and manage bladder and bowel disorders through self-management advice and exercise, short-course treatments and/or products (including home delivery)

- Supply continence products on the bases of (re)assessed need within the limits of the stated policy quantities, to patients/clients living in their own homes or in Residential/Nursing Homes and maintain appropriate data
- Lead and co-ordinate ongoing need to reduce Catheter Associated Urinary Tract Infections (CAUTI)
- Non-housebound patient/citizens who require support to manage long term and intermittent catheters shall be able to access the service.

Podiatry

- Provide high quality community podiatric care delivered efficiently and cost effectively to increase mobility and independence for adults. In this context quality is defined through clinical effectiveness, patient experience and safety
- Ensure patients are seen appropriately in relation to their urgency of need and discharged once their foot condition improves where it falls below clinical criteria for NHS funded service or can be managed appropriately through self-care
- Provide assessment and intervention for those patients with painful foot conditions (B1 activity only) where this has reduced mobility and independence Provide a surgical option for painful deformed nail pathologies
- Provide management of foot pain associated with foot function and/or structural abnormalities for foot and ankle conditions
- Provide footwear advice and other orthotics as part of personalised care plans
- Provide community based podiatric surgery with accessible x-ray facilities
- Establish and maintain links with acute-based specialist podiatry services to step up and step down patients as needed and ensure that staff are upskilled to manage more complex patients in the community
    - Where CityCare receives a referral for the decommissioned activity it is agreed between the Parties that these have prior approval to be seen by CityCare via this Contract Variation
    - No referrals for B2 activity should reach NHT or be accepted without prior triage by the patients GP
    - The Parties have jointly agreed that there is no financial value attached to the undertaking of the decommissioned activity in the first instance despite the activity recognised as occurring out with of the commissioned service
    - Both Parties agree to regularly monitor referrals for the decommissioned activity and whilst no contractual obligation to report, will do so via the Contract Monitoring meetings
    - Where CityCare begins to incur additional costs of delivering the decommissioned activity beyond the commissioned financial envelope and can demonstrate the increase cost, it will raise this with the CCGs and evidence accordingly. Prior approval for any cases which would take the Trust beyond the commissioned financial envelope need to be agreed with the CCG on a case by case basis in advance of the activity taking place. It is agreed that despite the activity falling out with of the contract, the process to be followed in this instance will be:
        - Provider to raise an Activity Query Notice (no specified time period; exception to the NHS Standard Contract))
        - Activity Management meeting held within 10 operational days of AQN being raised
        - Agreement out of the meeting that either the AQN is accepted and therefore the additional costs incurred will be paid for (exception to the NHS Standard Contract) OR
        - Further detailed meeting to jointly review activity management following which there is expected to be an agreement on the additional costs and

whereby this is reached, the CCG accepts through this CV that it would then pay those additional costs.

- The joint review meeting may agree to withdraw the Prior Approval of the decommissioned activity to support CCG management of demand, or may put in place other thresholds that would limit the financial consequences to the CCG. It may also agree that the Provider undertakes a change in its capacity management to reduce the activity in line with the commissioned contract envelope. In this latter instance any costs already above the commissioned envelope incurred would be paid for, accepting no future costs would be as a result of what may be agreed to be put in place as a consequence.

Diabetes

- Ensure that the healthcare professional delivers all 9 care processes (weight, blood pressure, smoking status, HBA1c, urinary albumin, serum creatinine, cholesterol, eyes and feet) to patients with Type 1 and with support of Primary Care record Type 2 Diabetes

Case Management

- Aim to case manage by undertaking regular visits to patients/citizens (as decided by the case manager or in-line with clinical guidance), pro-active monitoring of the patient/citizen through assistive technology), education, self-management techniques, provide support to the carer as well as the citizen
- Promote and identify patients/citizens eligible for Early Supported Discharge where citizens are hospitalised and provide a suitable model of care
- Support the patients to self-manage through using behaviour change and physical activity to reduce the risk of relapse and increase survival rates
- Use performance scales and outcome assessment tools to determine the phase of illness of a patient/citizen

End of Life

- Provide 24/7 registered Nurse/Healthcare Assistant at the home to support patients at the end of their life and for their carer
- Work alongside GP Practices to use the EPaCCS (Electronic Palliative Care Co-ordination Systems) tool to support care for end of life decision and practice choices about palliative care
- The Provider will be expected to have respite care links, hospice at home and end of life services including links with Hayward House for example
- Deliver a bereavement support service for patients/citizens and those affected around the patient/citizen i.e. carers and their family i.e. providing information before, during and following death
- Deliver hospice out of home and day care services

Rehabilitation Programmes

- Aim to improve survival and reduce risk of relapse for cancer patients, patients with breathing difficulties due to a lung condition and/or respiratory condition, stroke patients and those with cardio vascular disease through a programme of exercise and education
- To deliver appropriate support to promote and monitor mobility and independence (this may include working with the acute sector to deliver joint clinics)
- To deliver appropriate support to improve a patients/citizens communication skills following a significant health related event or injury
- Provide time limited goal focused rehabilitation to patients/citizens identified as having a rehab need

Bone Health

- Provide an advanced level of clinical expertise in the assessment, diagnosis and management of highly complex patients, using specialist knowledge and skills with the area of falls prevention and bone health
- Aim to improve diagnosis and management of bone health in the community
- Administer IV infusions in the community where medically appropriate
- Deliver Denosumab infusions in the community. This includes purchasing and provision of drug and recharging CCG.

Urogynaecology

The Urogynaecology pathway will provide a Single Point of Access (SPA) service with clinical triage of all referrals and provide integrated pathways with other key services (for example Community gynaecology services).

The Provider will have in place agreed pathways and systems that:

- Ensure only those service users that need to be seen by a specialist hospital based service are referred onwards to secondary care
- Integrate with other services/ pathways for example Community Gynaecology Service
- Provide information to service users and their carers on their condition, and the ways it can be managed, and any support available in appropriate format and language
- Adhere to local policies, all diagnostic procedure good practice and guidance indicators, and national standards
- Ensure care is given in an appropriate environment
- Enable working with secondary care providers to provide an integrated surgical process including:
    - where appropriate follow-up in the community
    - comprehensive discharge planning
    - continuity of care in the community after discharge
- Education and counselling of patients and /or carers concerning:
    - the clinical condition
    - specific health education
    - reducing the possibility of recurrence of acute conditions
    - acceptance and management of chronic conditions including the efficient and appropriate use of medicines and equipment
    - self-care and self-management
    - prevention of further deterioration
    - personal remedial action related to lifestyle risk factors (e.g. stopping smoking, weight control advice)
- Ensure where diagnostics/tests have been carried out in primary care, or by other providers and the results shared, the diagnostics/tests must NOT be

duplicated by the service unless there is a clinical justification for doing so. The provider must ensure that any information received by primary care is shared effectively with relevant staff members and other service, if applicable, to ensure it is not duplicated.

- If on examination, the patient's clinical condition is not at the stage where a community intervention is required or appropriate, the patient must be returned to primary care with advice on management

Education, Information sharing, Transition

- Build on strength to utilise what resources are available in the community
- A menu of options for delivering structured education for Type 1, Type 2 diabetes to take into account cultural needs and good access for those people who work
- Offer 24/7 access to information and support when required by a healthcare professional; carer of patient/citizen
- Support the patient/citizen to self-manage through education, shared decision making using behaviour change and physical activity to reduce the risk of relapse and increase survival rates
- Provide dedicated clinical advice and support with the aim of providing people affected by cancer, lung and cardio vascular disease with the knowledge, skills and motivation to become and remain active
- Promote flexibility with young adults who may need to access the service before the agreed transition period in order to ensure that their education/health needs are identified appropriately
- Support patients/citizens with a progressive long-term neurological condition to self-manage, remain independent and prevent avoidable deterioration where possible
- Provide dedicated clinical advice and support with the aim of providing people affected by cancer, lung and cardiovascular disease with the knowledge, skills and motivation to become and remain active
- Promote education and training for all of the services within long term conditions and case management throughout the community (including Care Homes, GP Practices, community settings and bedded facilities) in order to ensure workforce are trained, mentored and upskilled
- Build on strength to utilise what resources are available in the community

Working with partners

- Work in partnership with primary care psychological therapy Providers to support delivery of 'integrated IAPT' pathways. Deliver holistic assessments for patients/citizens provided by all nursing and specialist staff in order to provide the foundations of each person specifically and acknowledge physiological, psychological, sociological, developmental, spiritual and cultural needs
- Work with pre-diabetes Provider such as the NHS Diabetes Prevention Programme to identify those individuals who are at risk of diabetes
- Ensure good links with the Local Authority understanding what lifestyle services are available for citizens
- Establish links with the Carers Hub to ensure that care and support for carers is identified proactively and delivered in an integrated way
- Work with a range of stakeholders and partners to help people age well, Improve physical and mental health and quality of life for patients/citizens

- Ensure there are appropriate links with the acute sector to promote easy access to specialist acute services such as orthotics, orthoptics etc
- Ensure good links with the Local Authority for easy access to Social Workers
- Expected to work with other Providers agreeing an advance care plan to determine decision making around a patient and use appropriate document tools
- Sharing information with other emergency Providers such as NEMS and EMAS
- Be expected to link into all available community based resources in order to provide patients/citizens with the appropriate information relevant to their health needs and to strengthen access of information

Audits

- Undertake regular audits and patient questionnaires to determine the outcome of the patient in order to improve care and meet the required standards agreed in the key performance indicators. (Benchmark, measure and continuously build on lessons learned);
- Completion and submission of Stroke SSNAP audit,
- Completion and submission of national diabetes audit,
- Training to be undertaken in Care Homes will be monitored by exception at contract meetings where Care Homes are not engaging with the training opportunities.

Risk Tools

- Liaise with GP Practices who will use an appropriate tool e.g. Electronic Frailty Index (eFI) in order to identify patients aged 65 and over who are living with moderate and severe frailty
- Liaise with the care co-ordination service in identifying care gaps using e-Healthscope (risk stratification tool) and proactively taking referrals to prevent acute attendances and admissions.
- Use performance scales and outcome assessment tools to determine the phase of illness of a patient/citizen
- Escalate any patient/citizen safety risks, raising concerns with relevant stakeholders
- Implement a pressure ulcer prevention and management plan in collaboration with Tissue Viability to ensure safe management of skin and wound care for patients/citizens

Assistive Technology

- Implement available forms of Assistive Technology in order to help patients/citizens to manage their condition in the community or at home

Care Planning

- Deliver holistic assessments for patients/citizens in order to provide the foundations of each person specific care and acknowledge physiological, psychological, sociological, developmental, spiritual and cultural needs
- Ensure that joint management care plans are carried out across services and these consider the patient/citizens mental health requirements
- Be expected to adhere to the adopted recommendation plan (as agreed in the core specification) for an individual citizens care in an emergency situation whom may be unable to communicate how they wish to receive care

Social Value

Support achievement of the Social Value objectives for patients and staff by (but not limited to):

- Facilitate access to self-help and self-management support
- Facilitate increased levels of mobility, exercise and physical activity
- Facilitate access to diet and nutrition education
- Facilitate access to smoking cessation programmes
- Facilitate a reduction in social isolation and improved mental health
- Facilitate employment and return to work opportunities
- Facilitate environmental sustainability

Categories of need

The following population groups will be most likely to access this service:

• Adults • Older people • Frail Elderly • Patients/citizens with co-morbidities • Long-term existing patients	• Multiple physical and mental health morbidities requiring complex care • Newly diagnosed with an LTC/LTNC (long tern neurological conditions) • At risk of hospital admission/re-admissions	• Patients/citizens deemed as approaching end of life • Obesity, weight management, nutrition • Patients/citizens requiring case management • Patients/citizens with a swallowing/communication need • Housebound

Long Term Conditions breakdown

The Provider will be responsible for delivering relevant interventions for the following conditions:

Service/Condition	
Frailty, Risk of hospital admission	Providing case management for complex patients, End of Life/Palliative care, Falls, Bone health, Frailty, Nutrition, Skin and Wound care, Pain Management, Symptom Control, Continence/Catheter Management
Cardiac, Heart Failure, Stroke, TIA, Support and Rehabilitation	Coronary Heart Disease, Heart Failure, Cardiac Rehabilitation, diagnosed left ventricular systolic dysfunction, IHD, Acute coronary syndrome, Cardiac Surgery, Diagnosed stable angina, high risk of Cardiovascular disease (CVD), post stroke patients
Speech & Language Therapy	Communication, Dysphagia, Swallowing, Stammer, benign voice, laryngectomies, tracheotomy
Neurology	Brain, head and spinal cord injuries, Multiple Sclerosis, Epilepsy, Motor Neurone Disease, Parkinson's, post-polio syndrome, Cerebral Palsy, Huntington's Disease, Muscular Dystrophy
Integrated Respiratory Service and Home Oxygen Service	Asthma, Bronchiectasis, COPD and Interstitial Lung Disease, Cluster Headaches
Cancer	All diagnosed cancers

Diabetes	Pre-Diabetes, Management of Type 1and2 Diabetes, Structured Education programmes, NHS Diabetes Prevention Programme and prevention of other conditions/comorbidities including Cardiovascular Disease, Stroke, Retinopathy, nephropathy and neuropathy
Podiatry	Nail, corn and callus care, ulcer and wound care, footwear/equipment assessment advice, podiatric surgery, specialist biomechanical assessment, foot health advice, palliative foot care, provision of orthoses
Falls and Bone Health	Osteoporosis, Falls, Frailty
Rehabilitation	Falls, Osteoporosis, Frailty, Neurological conditions, Cancer, Stroke, Respiratory, Speech and Language Therapy, mindfulness, end of life patients and citizens identified through evidence who would benefit from rehabilitation
Palliative Care	All conditions including frail elderly
Community Nutrition and Dietetics	Weight management, allergies, complications related to diabetes, hyperlipidemia, gastrointestinal conditions, malnutrition/nutritional support, specialist dietetic support, case management of malnutrition, dietetics management, oversight and direction of ongoing supplies of oral nutrition supplements
Continence	Bladder, bowel conditions, Urology, Gynecology, Continence Prescription Service
Other	Breast drains, Nephrostomy flushes, Doppler testing, leg ulcer clinics, administration of medication, ear syringing, stoma care

Criteria for service use (Threshold for accessing services)

In order to access these services the patient/citizen **MUST** be:

- Registered with a GP Practice within Nottingham City
- Over the age of 18 years or agreed an individual patients in transition

And have at least **one** of the following:

- Have at least **one** suspected or confirmed diagnosis of a long term condition
- Require case management due to their condition
- Require re-ablement/rehabilitation
- Patient/citizen deemed to be within the last 12 months of life in accordance with the Nottinghamshire End of Life Care Pathway (2009)
- Be at risk of hospital admission or readmission

Criteria for Podiatry Service (exclusion):

- Patients with low/no medical need and painful podiatric need (classified as B2 patients) and low medical and low podiatric need (classified as B3) which includes:
    - Painful corns/callus
    - Neuropathic callus
    - Neurovascular corns

Criteria for Podiatry Service (inclusion):

- Exceptional cases that are still allowed within the criteria (which do technically fall into the B" category) are patients with:
    - Biomechanical/MSK problems
    - Painful deformed nails e.g. involution which require nail surgery

Workforce

The workforce model will be led by a CDG clinical lead and a combination of professions with a wide range of physical and mental health skills and levels. The core workforce will consist of GPs, access to Consultants (e.g. Diabetologists and Respiratory/COPD Consultants) and Geriatricians (both remotely for advice), Nursing staff and Healthcare Assistants. Condition specific and specialist staff (including non-medical prescribers) should be included to ensure that the patients' needs are met and are case managed appropriately and have access to a well-trained specialist workforce.

Condition specific/specialist staff including: Respiratory and Home Oxygen Nurse, Diabetes Specialist Nurses, Specialist Stroke Nurses, End of Life and Palliative Care Nurses, Neurology Specialist Nurses and Heart Failure Nurses, Specialist Mental Health Nurses, Rehabilitation Nurses and Social Workers, Specialist Continence Nurse/Advisors, Podiatric Surgeons, Consultant Diabetologists, Consultant Respiratory Physician.

Acute and community based Allied Health Professionals: Speech and Language Therapists, Occupational Therapists, Dietitians and Dietitians with a special interest in Diabetes, Podiatrists and Podiatrists with a special interest in Diabetes, Assistant Practitioners and Physiotherapists, Rehabilitation Support Staff, Stroke Therapists

Non-Clinical professionals: Care Support Workers, Support Workers, Care Co-Ordinators, Smoking Cessation Workers