Service	Integrated Community Services – Rushcliffe, Nottingham North and East (Synergy Health, Arrow Health, Arnold and Calverton and Bryon Primary Care Networks), Nottingham West PCN as part of South Nottinghamshire Place Based Partnership
Service Specification number	INT02

National/local context and evidence base

15.4 million adults in England have a long-term condition, almost 1 in 3 people. The ambition to move care closer to home has resulted in some reduction in lengths of stay in hospital, but further significant changes are needed in the way care is delivered.

The aim of integrated multi-disciplined teams is to:

- Reduce complexity of services– the reduction of fragmented services and tasks will improve consistency and quality of community care. This is achieved through creating larger integrated locality facing teams with a shared set of skills and assessment processes which includes staff with specialist knowledge.
- Wrap multi-professional services around the patient who are part of a larger primary care team – both generic and specialist staff with defined goals.
- Multidisciplinary teams providing care for people with complex needs, including social care, mental health and other services. This should also include close involvement of patients and their carers in setting goals and planning care.
- Support teams with specialist medical input, with consultant services particularly for older people and those with chronic conditions.
- Create services that offer an alternative to hospital stay. Two components to this are proactive services which prevent admission and reduce length of stay. Preventing admission requires accurate assessment rapidly and responsive alternative service provision.
- Have an infrastructure to support the model based on these components including better ways to measure outcomes.
- Develop capabilities to harness the power of the wider community.

“Achieving integrated care would be the biggest contribution that health and social care services could make to improve the quality and safety” National Voices, 2011.

The aim of the integrated community service model is to provide a seamless, holistic health care service within a person’s own home, including long term residential care and/or clinic settings, and education settings. This is achieved through delivering care that is based on a person’s needs, wrapping the service around the patient to make it meaningful.

2.1 Local defined outcomes

NHS Midlands and East has agreed 5 key ambitions regarding service improvement which includes:

1. The elimination of stage 2,3 and 4 pressure ulcers
2. Making every contact count.
3. To improve quality and safety in Primary Care
4. Strengthen partnerships between the NHS and local government.
5. Create a revolution in patient and customer experience.

Commissioner specific outcomes

6. Patient centred and high-quality co-ordinated health and social care services
7. Care which is closer to home and community based leading to a reduction in emergency admissions and length of stay in the over 65s and those with long term conditions
8. The prevention of unnecessary admission, or readmission, to hospital or long-term care
9. The maximisation of independent living and residual skills
10. The prevention of avoidable deterioration and promotion of optimum levels of independence and self-care appropriate to individual need and ability
11. EOL patients die in their preferred place of death
12. Provide a high-quality pulmonary rehabilitation based on NICE Guidelines which improves respiratory function, symptoms, quality of life and independence
13. A case management and care planning approach is used to maximise patient care
14. Patients and carers report a high level of satisfaction and experience of services
15. Staff have the skills, capacity, and capability to deliver excellent patient care

3.1 Aims and objectives of service

Aim

The aim of the integrated community service model is to provide a seamless, holistic health care service within a person's own home (including residential care, and in the case of enhanced services to nursing homes). This will be achieved through delivering care, which is patient centred, wrapping around service provision to make it meaningful to the patient.

The integrated teams will case find frail older people, by utilising predictive and risk stratification tools to actively case find and identify patients who are most vulnerable from admission and/or health deterioration. The teams will support patients manage their health conditions and to achieve the best quality of life and independence possible through robust health assessments and care planning.

The aims and objectives of the integrated service will fit within the three core QIPP domains of efficiency, effectiveness and patient experience.

Objectives

- To create access to better, more integrated care outside hospital through the
  delivery of an integrated community health service which works in partnership with health and social care teams including mental health services, social care, secondary care and the voluntary sector to ensure person centred care is provided.
- To provide an Urgent Community response and crisis intervention 7 days per week, between the hours of 0800-2200
- To simplify and streamline access to adult community services through the provision of a Single Point of Access/Community Hub for all enquiries and referrals for adult community services from GP Practices, social care, secondary care and patients and any other agencies such as police, which operates 8am to 8pm 7 days a week.
- To work closely with General practice, attending MDTs to identify those with deteriorating health, increasing health and social care needs to proactively manage and provide wrap around care promoting independence and self-care.
- To reduce duplication and gaps through the effective management of integrated teams
- To reduce unnecessary admissions and readmission through proactive case management, liaising with secondary care to actively facilitate safe effective transfers both in and out of acute sector care in a timely manner and reduce overall length of stay/avoid inappropriate admission where appropriate.
- To ensure that integrated health services are patient centred and equitable
- To utilise predictive and risk stratification tools to actively case find and identify patients who are most vulnerable from admission and/or health deterioration.
- Work in partnership with Adult Social Care and care agencies to provide a holistic health and social care package to support independence.
- To contribute to the reduction of unplanned care needs, reduction of hospital admissions and readmissions, reduced length of stay, and the reduction in the number of people requiring long term residential care.
- To support patients receiving end of life care to die with dignity, supported in their preferred place of death
- To scope, plan and develop planned care services as appropriate.

3.2 Service description/care pathway

Referrals into Integrated Care Teams:

All referrals to be actively triaged by therapy and nursing staff to ensure appropriate, efficient utilisation of services and ensure services are 'wrapped around' the patient according to patient needs. This will be achieved through a single point of access through a single approach. Triage from therapy and nursing staff to streamline the patient journey, reduce duplications and improve consistency of service delivery. Actively engage and promote horizontal and vertical integration with mental health services for older people.

Urgent Community Response: not included in 201718

To provide an urgent community response (UCR) service to patients to prevent an admission into hospital. This service will be available between the hours of 0800-2200 7 days a week including bank holidays with clinical advice and support being available and will accept referrals into crisis response services from all appropriate sources.

A 2 hour UCR service will be available that meets the National UCR Mandate: to operate within the hours as detailed above, accept referrals from any health care professional and self-referrals via 111 and meet all requirements outlined in NHS England » Community health services two-hour crisis response standard guidance.

The service will submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard.

In 201718 this was

Avoided Admission:

To provide a rapid response service to patients needs in order to prevent an admission into hospital.

Care Co-ordination:

The service will support the Care Coordination Team at admission/discharge from NUH through in reach and the proactive pull patients into community services. This will be based on the following principles:

- Care coordination will be collaborative across health and social care colleagues, community and NUH nursing and therapy and social care staff
- Care coordination will support the identification and tracking those patients with an anticipated complex discharge from the point of admission (choose to admit)
- A pro-active pull of the patient through the system from acute to community/primary care
- Care coordination will support a programme of care that is established and maintained throughout the hospital stay
- Care coordination will aspire to one assessment carried out to meet the needs of transfer to assess
- Care coordination will support patients to be transferred to on-going care within 24 hours of being flagged as medically stable
- There will be a shared understanding across the hospital / community interface to ensure risk is managed
- There will be consistent communication / use of language with the patient and carer regarding the transfer of care and how their on-going care needs will be met

Transfer to assess

To facilitate a reduced length of stay with swift, timely, safe discharges into the community with community follow up to reduce readmissions and support further self-care management and to assess on-going health needs.

Support Monthly Multi-Disciplined Team Meetings (MDT)

To be held within the GP practice. Appropriate members of the integrated team to be the patient advocate as well as clinically discuss on-going care management across the wider integrated team. There will be a clear identification of a case manager and service lead for the care pathway of individual patient, based on the needs assessment.

Implement Advance Care Planning

The integrated team will work closely with established lead, patients, relatives and primary care, secondary care/specialist palliative care to ensure that advanced care plans are discussed with the patient, family and where appropriate care staff.

Preferred place of death wish is to be clearly documented, and the wishes of the patients supported as much as possible with multidisciplinary advance care planning arrangements as well as assessing/ confirming/ documenting the mental capacity of the patient. ‘Special Patient Notes’ and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms are to be accurately completed and registered with out of hour’s providers and community teams and are available to East Midlands Ambulance Service (EMAS) on arrival to the home and through the EMAS electronic systems.

The identified lead will also be responsible for ensuring that the end-of-life care plan is discussed with patients and their relatives as appropriate. Advance care plans, patient wishes and DNACPRs will be held both in the patient's notes and (for patients in long term residential care) by the care home staff.

The GP lead is responsible for updating the GP records, and 'THE PROVIDER' are responsible for documenting on the community module of the patient records. Anticipatory medications will be discussed with the GP to ensure proactively anticipatory prescribing to avoid crisis when the patient deteriorates, this will particularly support the out of hours, or if applicable by the non-medical prescriber in discussion with the GP. These plans will be clearly available for secondary care providers and transport providers.

Personalised Care Plans
Personalised care plans are required for all patients who have a long-term condition to assist them to achieve a self-care management plan, to include escalation advice should their health deteriorate. There is to be an emphasis on self-care, management of exacerbations and rescue and anticipatory medications management.

Utilisation of Digital Technologies
To support patients with self-care management and promote ownership of patients own health and health management. Utilisation to be promoted particularly for residents in residential care homes to support care home staff in early identification to changes in the patients' condition and increase the care assistant's knowledge of normal and abnormal parameters, implications and management.

Self-Care
To support Self-Care is a key principle promoting 'support to thrive'. Patients to have a proactive, patient centred care plan, which is communicated between teams and organisations as appropriate and with patients, so they understand the personalised care plan. Care plans to also include clear instructions for anticipatory medications such as recurrent respiratory infections, recurrent urine infections etc.

Signpost to other relevant services
Community teams will signpost patients and carers to relevant support groups where appropriate, to improve the patient and carer experience. The provider will help to facilitate patient and carer support groups were possible inputting with expertise, venue if available and facilitation.

Diagnostics
To support diagnosis and on-going management such as phlebotomy/urinalysis etc for patient on the community caseload or who have been referred for assessment.

Medication reviews
Medication reviews to be undertaken according to the patient need and these will be communicated to other key services involved in the patient journey as appropriate.

Admin and data support
Underpinning the work of the integrated care teams, the provider must have a support function to provide administration and data support to ensure clinician time is utilised effectively and aid integrated working.

Conditions managed:
Long term conditions
Long term conditions to be managed in a community setting, to include injection therapy, either short term e.g., anticoagulation, and/or long-term therapy e.g. insulin/B12. This is not exhaustive and will encompass future initiatives within service improvement across the community and acute sectors.

Community teams will ensure good communication with acute consultants whenever necessary, ensuring patients receive the right level of care in the right place.

Community geriatrician
To work closely with the community geriatricians as an integral part to the integrated team. The community geriatricians will be used as a resource to manage complex patients, which include complex

fallers and neurological conditions (including Parkinson patients), as well as provide opportunity for sharing best practice, teaching and education, this includes support in MDTs. Community team will use this service for specialist advice & support.

Care home support
Working closely with care home staff to improve the confidence of staff and jointly proactively identify and manage deteriorating health including end of life care to reduce avoidable unplanned admissions.

This is achieved through supporting 'bite sized' training as identified by care home staff and community staff. The service will be supportive with specific initiatives in conjunction with Primary Care to reduce avoidable hospital admissions

End of Life
Adopt overarching end of life principles across all the services, so patients are identified early, care plans are agreed, and end of life care supports a dignified end of life. Patients are identified as appropriate to the 'gold standard framework' and discussed at the GSF or other appropriate meetings.

To ensure anticipatory medications are available in a timely manner. To support patients, carers and significant others to provide holistic, end of life care in a compassionate, dignified way. The provider will work with other organisations to ensure a dignified end of life, so patients and relatives feel supported e.g. Hospice at home.

The provider will support patients in their preferred place of death. Continuing Healthcare will be utilised when appropriate.

The provider will ensure that a Community Macmillan Specialist Cancer and Palliative Care Service is provided consisting of Community Macmillan Nurses who provider care to cancer patients from the point of diagnosis. They will support patients and their carers, to prevent unnecessary hospital admissions from the point of diagnosis through to death, including carer support and following bereavement where these needs cannot be met by other low-level bereavement services and normal grief reaction.

The service shall provide support, training and education sessions 'teaching clinics' to all practices in Nottinghamshire County (south). A named Community Macmillan nurse will be assigned to each practice and will be responsible for ensuring that practices access the support required.

Specialist Continence and Urology Service – different to Rushcliffe and NNE 201617
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.

The Provider will:
- Assess and manage complex bladder and bowel disorders through self-management advice and exercise, short-course treatments and/or products (including home delivery). Non-complex would also be provided within level 1 with referral up to level 2 if clinically required.
- Supply continence products on the bases of assessed need within the limits of the stated policy quantities, to patients living in their own homes or in Residential/Nursing Homes; maintain an appropriate patient level database of assessment, supply and usage and provide budgetary management for the home delivery service.
- Contribute to the reduction of Catheter Associated Urinary Tract Infections (CAUTI).
- Provide education, support, advice and practice development to all healthcare professionals within primary care, secondary care, social services, independent sector and care homes.
- Develop and monitor a continence appliances formulary ensuring standardisation of quality, cost effective products that need to be utilised within all areas.
- Respond to emergency and planned domiciliary visits for complex catheter issues in partnership with non-specialist community nursing teams if clinically required.
- Provide telephone support, training and education to primary healthcare professionals and patients for complex catheter care.
- Develop treatment plans for patients and support primary care health professionals in the development of treatment plans for complex catheters.

- Facilitate direct referrals or admissions for patients in the community whose condition worsens, via liaison with the hospital urology department to facilitate for complex catheter care.
- Provide a link to the hospital from diagnosis through treatment to follow up complex catheter care.
- Provide direct clinical support via integrated pathway with acute Urology Consultant.
- Be responsible for issuing repeat prescriptions for continence appliances. All patients registered with South Nottinghamshire GP practices who require prescriptions for continence appliances will be enrolled in the service; the responsibility for issuing repeat prescriptions for continence appliances will lie with the service.
- GP practices will no longer deal with requests for prescriptions for continence appliances from appliance contractors, pharmacies or patients; items such as catheters (indwelling and intermittent), drainage bags, external sheath drainage systems etc. will now be prescribed by the Continence Prescription Service.
- The service will be integrated within the Specialist Continence service model.
- This service will review and monitor all patients regularly and prescribe all continence products accordingly with the formulary, enduring that service users receive a timely, efficient, and tailored prescribing service according to their needs.

Expected Outcomes including improving prevention
All patients over the age of 18 for south of Nottinghamshire County patients, who have bladder and/or bowel problems, will receive a holistic and individual assessment, appropriate treatment and management of their continence problem.

All carers and healthcare professionals within the whole health community who care for a person with bladder and/or bowel problems will have access to specialist education, advice, support and clinical practice development in continence care.

There will be an effective and efficient home delivery service for the provision of incontinence pads to people in their own homes, residential and nursing homes.

Specialist tissue viability
To provide specialist wound care advice for the assessment and management of any patient with healing problems. Specialist staff will provide advice to patients and the staff caring for them on an individual basis to promote wound healing and prevent deterioration or recurrence.

The Tissue Viability service will:

- Provide expert advice and support to healthcare professionals involved in all aspects of tissue viability and wound care.
- Provide specialist assessment and advice on complex and non-healing wounds, or wounds with an unusual aetiology Be responsible for the provision of specialist therapies i.e. topical negative pressure, larvae and wound debridement, including specialist therapies funded by continuing care.
- Provide telephone advice during office hours.
- Assess patients and provide pressure relieving equipment via the Integrated Community Equipment Store
- Advise the Integrated Community Equipment Store on the acquisition of pressure relieving equipment and strategies for the management of pressure relieving equipment.
- 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.
- Undertake Continuing Care assessments for pressure relieving equipment, including reviewing patients as necessary.
- Confirm and challenge decision making on all stage 3and 4 pressure ulcer Root Cause Analyses within community services
- Advise pharmacies and supplies departments regarding the acquisition and management of wound care products
- Develop / implement and regularly review policies, protocols, formularies, documentation and guidelines
- Undertake research and clinical audit relevant to the continuous development of the service.

- Operate a Tissue Viability Link Nurse system, running full day study days 3 times a year and a conference as appropriate
- Be responsible for delivering monthly in-service training packages on all aspects of tissue viability to registered and non-registered staff.
- To deliver a Tissue Viability service in line with national frameworks, local trust policy and commissioning requirements.
- Confirm and challenge decision making with Suspected Deep Tissue Injuries and ensure accurate reporting once status is established
- Manage the 'alert' process across the patient pathway to ensure ownership of the pressure ulcer by the relevant provider
- Provide three half days a year of tissue viability training to private nursing homes within the south of the county
- Provide detailed reports for HM Coroner's office, as requested utilising specialist nursing expertise
- Monitor numbers and healing rates of PU damage and determine actions to reduce these.
- Work with other providers where PU damage is related to patient pathway spanning organisations to determine improvements and learning to avoid future reoccurrence.

Therapeutic Rehabilitation

- **Primary care rehab**

Identify specific 'hot spots' where support and education to local primary care teams, general practices and care homes would contribute to a reduction of falls. Provide expert advice and support to Primary Care staff, community staff, care homes and home care staff to embed "falls are everyone's concern".

Provide falls training and embed the 'prevention of falls' action tool within all community services. Undertake a multidisciplinary assessment and treatment aimed at preventing future falls. Liaising with other key stakeholders as needed and identify how service intervention has reduced risk of falls.

This includes support for neuro-Huntington's patients.

There is expected to be no waiting list due to the effective triage processes.

- **Therapeutic reablement at home**

A multidisciplinary assessment and treatment aimed at promoting rehabilitation and independence.

Please refer to the Short-Term Health and Social Care Rehabilitation Services Model for a full overview of all levels.

Level 1 (includes high, medium and low levels of need):
Provides services for people in their own home. These services will deliver in partnership with other providers and services independence training for people across a spectrum of needs from low level to high levels of Rehabilitation.

Staff will differentiate in goal planning between 'doing for' and 'doing with' to ensure the person achieves their goals as identified in personalised care plans.

People will receive Care from staff that has been Specifically trained by rehabilitation and Reablement specialist Occupational Therapy trainers and deliver rehabilitation plans and goals under varying levels of oversight from specifically trained rehabilitation therapists.

The services will then be delivered to meet a range of people from low levels of needs requiring only minimal interventions in assistance with washing, dressing and undertaking basic self-care tasks essential to maintain the lowest possible level of dependence upon other services and designed to maximize people's ability to regain their original levels of independence.

Services will then be delivered up to higher levels of care which require significant interventions to support people with complex conditions, to include complex fallers and neurological conditions (including Parkinson's patients).

It is expected that the provider will work with the community geriatricians to ensure medical oversight of complex patients ensuring responsive pharmacological management and medical assessment along with a robust link with secondary care clinicians. This will support more complex frail and elderly patients (including those with Parkinson's Disease).

These people are likely to have limited mobility to transfer and/or nighttime needs which may require a range of more intensive nursing, rehabilitation and specialist OT/Physio therapist support to achieve the highest levels of independence attainable within the shortest period possible and no longer than 6 weeks.

Community based rehabilitation within a person own home will be:

- Managed by primary care, community services and providers working collaboratively
- Range in degree of professional oversight from low levels of needs from unqualified rehabilitation support staff to qualified therapist and nursing practitioners.
- Ensure relevant equipment is available to therapy staff and patients, which is relevant to the individual's stage of illness.
- Ensure therapy is provided in a clinic setting where clinically indicated.

As soon as their goals have been met even if this is sooner than initially predicted.

- Or if their condition deteriorates and their needs increase and cannot be met within the agreed rehabilitation and assessment period
- People may also have an increased level of need but remain with the service as the revised goal plan for rehabilitation can still minimize the levels of ongoing care they are likely to need.

Levels of qualified staffing interventions will therefore be flexible across the services to meet the range of levels of needs Moderate intervention for more complex conditions means but with additional OT oversight of goal planning and training for the person and to assist Reablement Workers on problem solving. May require some additional nursing, OT and/or Physio input to support the person to achieve independence.

People will clearly decrease in the levels of needs that they present with daily and be subject to a constant assessment and review process individually tailored to ensure that people are discharged from the service:

Low level will be comprised of:

- Independently mobile
- Mobile with minimal aids and adaptations
- Struggling to manage basic personal hygiene tasks following fracture / surgery
- Struggling to dress following fracture / surgery
- Lack of confidence managing independent living following a fall / illness and needing to re-establish confidence
- Disorientation and anxiety of independence living following hospital admission / illness and needing to be re-established at home through support and oversight of basic independent living tasks

Medium level will be comprised of:

- Needs 1 to transfer
- Mobility needs improving and may not improve longer term, but assessment is needed of improvement and relevant aids and adaptations
- Unable to independently manage basic personal hygiene tasks following fracture / surgery
- Unable to dress following fracture / surgery
- No confidence managing independent living following a fall / illness and needing to re-establish confidence
- Severe disorientation and anxiety of independence living following hospital admission / illness and needing to be re-established at home through support and oversight of basic independent living tasks
- May also need some nursing interventions for medication and / or dressings / IV pegs etc.
- May need physio / OT therapy input

High level will be comprised of:

- Needs 2 to transfer or is immobile

- Needs period of ongoing assessment to provide appropriate level of ongoing aids and adaptations
- Unable to manage basic personal hygiene tasks following fracture / surgery
- Unable to dress following fracture / surgery
- No confidence managing independent living following a fall / illness and needing to re-establish confidence
- Disorientation and anxiety of independence living following hospital admission / illness and needing to be re-established at home through support and oversight of basic independent living tasks
- Needs higher levels of nursing interventions for medication and / or dressings / IV pegs etc.
- Needs physiotherapy input and other specialisms SALT / OT etc.

Assessment Process:
The assessment process for each service area MUST be compatible with other provider areas and delivered in the same manner to reduce the need for assessments to be re-done to deliver the same outcomes or a continuation of outcomes.

Services will ensure that the assessment process, tools and training is clearly linked to enable transitions to occur between services without duplicated assessment occurring or a change in the approach to rehabilitation or outcomes

Integrated Care for Long Term Conditions including Frailty and End of Life Care (Nottingham West only):
See Appendix 1 for further supporting information.

Aims and objectives
To operate a specialist nursing service which delivers care, closer to the home in a holistic manner with the potential to reduce emergency admissions and reduce length of stay. The aims of the service are to provide patients with specified Long-Term Conditions (LTC) with evidenced based care.

Targeting services at patients with complex on going needs such as the frail elderly or those with chronic conditions including Diabetes, Cardiology, Respiratory and End of Life Care.

Aims:
- Assessment and management of clinical status
- Lifestyle assessment including nutrition and exercise/rehab
- Pharmacological management
- Support and education for both patients and their carers
- To support the existing specialist and generalist services supporting patients with long term conditions and at the end of life; including Specialist Nurses, District Nursing, Community Matrons, GPs, Specialist Palliative Care services etc.
- To reduce the number of unplanned admissions and A&E attendances to secondary care for patients.
- To provide a seamless transition of care for those patients receiving LTC specialist nursing who then require End of Life specialist nursing.
- To increase the number of patients registered with GPs in Nottingham West who can die at home if they choose to do so.
- To utilise GP and consultant mentorship surrounding Long Term Conditions.

Objectives:
- Reducing recurrent hospital stay
- Improving clinical outcomes by slowing down the rate of disease progression
- Prolonging life and improving quality of life
- More efficient service – clearer pathway
- Providing care in the community
- Reducing impact on secondary care and subsequently, 18 week wait
- Provide clinical Leadership and coordination of the service.

The provider must work alongside secondary care to reduce hospital admissions and to support hospital transfers and support greater communication between the specialist wards and the community.

All referrals to be actively triaged to ensure appropriate, efficient utilisation of services and ensure services are 'wrapped around' the patient according to patient needs. Actively engage and promote horizontal and vertical integration with mental health services for older people.

Specialist Nursing:
See appendix for further supporting information.

The provider must work alongside secondary care to reduce hospital admissions and to support hospital transfers and support greater communication between the specialist wards and the community.

All referrals to be actively triaged to ensure appropriate, efficient utilisation of services and ensure services are 'wrapped around' the patient according to patient needs. Actively engage and promote horizontal and vertical integration with mental health services for older people.

Heart Failure (Rushcliffe and Nottingham Northeast only)
Patients with confirmed heart failure to be case managed by specialist heart failure clinicians within the community if appropriate to reduce hospital admission maximise self-care and self-management and recognise worsening symptoms utilising personalised care plans to prevent exacerbations and ultimately preventing premature death.

Provide case management for patients who have a confirmed diagnosis of heart failure, to include medications optimisation, personalised care planning, cardiac rehabilitation, telehealth, effective dietary advice, crisis avoidance and supported discharge The heart failure service will support vertical integration with secondary care, and horizontal integration with the wider community teams, local authority, primary care and voluntary care services. To maximise service delivery, the heart failure service will be delivered within clinic settings as well as via domiciliary visits.

Where there is deemed to be limited impact from this service, due to patient condition, referral on to more appropriate services e.g. End of Life/community nursing teams for pressure ulcer avoidance.

Respiratory
Patients with known respiratory disease to be managed by specialist respiratory clinicians within the community to reduce hospital admission, maximise self-care and self-management and recognition of worsening symptoms utilising personalised care plans to prevent exacerbations and ultimately preventing premature death.

Provide case management for patients who have a respiratory disease, to include utilisation of rescue medications where appropriate, medications optimisation, personalised care planning, pulmonary rehabilitation, telehealth, crisis avoidance and supported discharge The service delivery will also include the home oxygen service and annual review for patients predominantly with respiratory disease, but also patients how receive home oxygen for other long term and/or life limiting conditions.

The respiratory service will support vertical integration with secondary care, and horizontal integration with the wider community teams, local authority, primary care and voluntary care services. The respiratory service will be delivered both in clinic settings and through domiciliary visits, supported by a respiratory consultant.

Diabetes
Patients with confirmed diabetes to be managed by practice teams/community teams within the primary care setting with the support of specialist diabetes clinicians. The outcomes are a reduction of hospital admission rates, maximisation of self- care and management and utilisation of personal care plans to help reduce the risks of long-term complications and premature death associated with the disease.

Medication optimisation, referral to appropriate support services and personalised care planning will be an integral part of this service

The service delivery will include supporting practice nurses and GP's and upskilling them to a level which enables delivery of high-quality diabetes care to all patients with type 2 diabetes. This service will primarily be delivered within the GP practice clinic setting but via domiciliary visits as and when necessary to certain individuals.

The Diabetes Specialist Nurse (DSN) will be expected to support the follow up of patients identified as at risk of further hypoglycaemic events (as per EMAS hypoglycaemia pathway) when the practice staff are unable to deal with this themselves.

Transition from Children's to Adult services:
The service will work in partnership with Children's and Adult commissioners, the Nottinghamshire Community Children and Young People's Healthcare Service (CCYPS) and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring support specific to this service specification to ensure seamless continuity of care during transition from children's to adult services.

Proactive planning and care pathways will be developed in line with local and regional transition guidance and the Together for Short Lives transition care pathway (http://www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework that can be adapted locally to plan services specifically for teenagers and young adults with life threatening, life limiting or complex medical conditions. The pathway sets out six standards that should be developed as a minimum, with the aim of achieving equality for all young people and families, wherever they live.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young adults during and following transition
- Use of Nottingham ICCYPH Programme Families' Statement of Expectations) as guiding principles
- Continuation of the personalisation approaches and systems used by the young person/adult
- Statutory duty to contribute to and provide services to young people/adults within Education Health and Care Plans (EHCP) up to age 25 in line with SEND legislation (http://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014)
- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions
- Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Networks. Further work is being undertaken locally regarding this document and therefore should not be seen as definitive guidance.

3.3 Population covered

- All patients registered with a General Practitioner in South Nottinghamshire Place Based Partnership (formerly Rushcliffe, Nottingham North and East and Nottingham West CCGs)
- Patients from the age of 18 years.

3.4 Any exclusion criteria and thresholds

- Residents below the age of 18 years.
- People not registered with a General Practitioner in South Nottinghamshire Place Based Partnership (formerly Rushcliffe, Nottingham North and East and Nottingham West CCGs)

3.5 Interdependence with other services/providers

- Primary care services
- General Practice
- Secondary Care services
- East Midlands Ambulance Service
- Nottingham Emergency Medical Services
- Care Homes staff
- Any locally determine providers
- Local Authority – social services and care agencies

• Mental Health Services • Medicines management teams • Red Cross (CiCSS)/Crossroads • Third Sector Organisations • Voluntary sector • Patients, Carers, Relatives.
Workforce Each Adult Community Care Team will be led by a locality clinical lead and have a mixture of registered nurses, occupational therapists and physiotherapists at a range of skill levels and with varied specialist skills as required to deliver the outcomes of the service. These staff will be supported by a workforce of unregistered community support workers and assistant practitioners.

APPENDIX 1 - Supporting information

- **Integrated Care for Long Term Conditions including Frailty and End of Life Care (Nottingham West only)**

Aims and objectives of service
To operate a specialist nursing service which delivers care, closer to the home in a holistic manner with the potential to reduce emergency admissions and reduce length of stay. The aims of the service are to provide patients with specified Long-Term Conditions (LTC) with evidenced based care.

Targeting services at patients with complex on going needs such as the frail elderly or those with chronic conditions including Diabetes, Cardiology, Respiratory and End of Life Care.

Aims:
- Assessment and management of clinical status
- Lifestyle assessment including nutrition and exercise/rehab
- Pharmacological management
- Support and education for both patients and their carers
- To support the existing specialist and generalist services supporting patients with long term conditions and at the end of life; including Specialist Nurses, District Nursing, Community Matrons, GPs, Specialist Palliative Care services etc.
- To reduce the number of unplanned admissions and A&E attendances to secondary care for patients.
- To provide a seamless transition of care for those patients receiving LTC specialist nursing who then require End of Life specialist nursing.
- To increase the number of patients registered with GPs in Nottingham West PCN who can die at home if they choose to do so.
- To utilise GP and consultant mentorship surrounding Long Term Conditions.

Objectives:
- Reducing recurrent hospital stay
- Improving clinical outcomes by slowing down the rate of disease progression
- Prolonging life and improving quality of life
- More efficient service – clearer pathway
- Providing care in the community
- Reducing impact on secondary care and subsequently, 18 week wait
- Provide clinical Leadership and coordination of the service.

- **Cardiology (Nottingham West only)**

Aims
To provide a community cardiology nursing service, taking into consideration the NHS and Social Care Long Term Conditions Model. By implementing this service Nottingham West PCN will be able to continue care outside of a hospital setting.

The aims of the service are to provide patients who have a confirmed diagnosis of Left Ventricular Systolic Dysfunction with evidenced based care:

- Assessment and management of clinical status
- Assessment of cognitive state
- Lifestyle assessment including nutrition and exercise/rehab
- Pharmacological management
- Support and education for both patients and their carers and healthcare professionals
- Palliative care
- Clinical and peer support for the Community Cardiology Nurse
- Providing a link into the End-of-Life Pathway

Objectives

- Reducing recurrent hospital stay
- Improving clinical outcomes by slowing down the rate of disease progression
- Prolonging life and improving quality of life
- Improving management of cognitive state
- Increasing patient choice
- More efficient service – clearer pathway
- Providing care in the community
- Reducing impact on secondary care and subsequently, 18 week wait

Service description

- The service will cover the registered population of Nottingham West
- It is expected that the service will be supported in the patient's home and community clinics and as such, will require daily travel throughout the region of Nottingham West
- It is the responsibility of the provider to secure premises from which the Community Cardiology Nurse will work.
- The initial paper-based review will be updated from the QOF Heart Failure register to establish patients who have had an echo and a confirmed diagnosis of Heart Failure with LVD. From this, the cohort of patients who will benefit from a cardiology nursing service will be identified.
- The nursing services are to be delivered full-time over 37.5 hours/week. Exact hours to be flexible according to meeting the cluster need and a pro-active approach to care.
- Clinical and management supervision is to be provided by the Provider, including on-going training and development. It is recognised that the clinical supervision may require the Provider to sub-contract with secondary care.
- Provider to offer a fully qualified nursing service including BHF adoption, Caledonian and Non-Medical Prescribing.

Service Model

The service will assess and treat patients through individualised care planning in relation to:

- Patient Education (self-management)
- Weight, blood tests, BP and heart rate
- Diet
- Titrating Medication/Prescribing
- General Health Status (physical and psychosocial)
- Care is to be pro-active, and intensity and frequency is to be dependent on whether the patient is high or low risk, where they are within their care regime and whether asymptomatic or symptomatic.
- Defining low risk patients as – knowledgeable about their condition and treatment, compliant with medication and diet, receiving adequate social support, not in need of changes.
- High risk patients are – poor understanding of their condition, a history of recurrent admissions, poor compliance with medication and diet, inadequate social support, unsuitable lifestyle.
- Care is to be provided through a combination of telephone, home visits and clinic-based care. Dependent on status, scheme of care should include a combination of:
    - First contact with 24 hours of receipt of referral and initial home visit within 72 hours

    - Weekly home visits for the first month
    - Visits at 2–4-week intervals
    - Weekly and monthly phone calls to reassess status
    - Community Clinic Assessment
    - Regular evaluation as to whether home visits to be extended
    - Re-evaluation is to be carried out if patient is readmitted to hospital
- Patients are to be regularly reassessed, and the amount of follow-up increased or reduced based on their clinical and psychosocial status.
- The Cardiology Nurse is to work towards maximising the impact of the intervention and limiting contact thereafter
- The Cardiology Nurse will only care for patients with a diagnosis of LVD by echo. Therefore, as mentioned above, a paper exercise will be carried out to determine the cohort of patients who have a confirmed diagnosis, what their status is, and from those, who will benefit from heart failure nursing services. The results of the review to be fed back and discussed with relevant GPs and a care plan established.

- **Heart Failure (Rushcliffe, Nottingham Northeast only)**

Aims

To provide a community heart failure nursing service, taking into consideration the NHS and Social Care Long Term Conditions Model.

The aims of the service are to provide patients who have a confirmed diagnosis of Left Ventricular Systolic Dysfunction with evidenced based care:

- Assessment and management of clinical status
- Assessment of cognitive state
- Lifestyle assessment including nutrition and exercise/rehab
- Pharmacological management
- Support and education for both patients and their carers and healthcare professionals
- Palliative care
- Clinical and peer support for the Community Heart Failure Nurse

Objectives

- Reducing recurrent hospital stay
- Improving clinical outcomes by slowing down the rate of disease progression
- Prolonging life and improving quality of life
- Improving management of cognitive state
- Increasing patient choice
- More efficient service – clearer pathway
- Providing care in the community
- Reducing impact on secondary care and subsequently, 18 week wait

Service description/care pathway

- The service will cover the registered population of South Nottinghamshire Place Based Partnership (Rushcliffe, Nottingham North and East and Nottingham West)
- It is expected that the service will be supported in the patient's home and community clinics and as such, will require daily travel throughout the region of NNE and NW
- It is the responsibility of the provider to secure premises from which the Community Heart Failure Nurse will work.
- The initial paper-based review will be updated from the QOF Heart Failure register to establish patients who have had an echo and a confirmed diagnosis of Heart Failure with LVD. From this, the cohort of patients who will benefit from a heart failure nursing service will be identified.
- The nursing services are to be delivered full-time over 37.5 hours/week. Exact hours to be flexible according to meeting the cluster need and a pro-active approach to care.
- Clinical and management supervision is to be provided by the Provider, including on-going training and development. It is recognised that the clinical supervision may require the Provider to sub-contract with secondary care.

- Provider to offer a fully qualified nursing service including BHF adoption, Caledonian and Non-Medical Prescribing.
- In NNE the service will liaise closely with
    - The Adult Community Care Team
    - The Single Point of Access for adult community services
    - The Primary Care Prescribing Advisers

Service Model

- The service will assess and treat patients through individualised care planning in relation to:
    - Patient Education (self-management)
    - Weight, blood tests, BP and heart rate
    - Diet
    - Titrating Medication/Prescribing
    - General Health Status (physical and psychosocial)
- Care is to be pro-active, and intensity and frequency is to be dependent on whether the patient is high or low risk, where they are within their care regime and whether asymptomatic or symptomatic.
- Defining low risk patients as: knowledgeable about their condition and treatment, compliant with medication and diet, receiving adequate social support, not in need of changes.
- High risk patients are those who show poor understanding of their condition, a history of recurrent admissions, poor compliance with medication and diet, inadequate social support, unsuitable lifestyle
- Care is to be provided through a combination of telephone, home visits and clinic-based care. Dependent on status, scheme of care should include a combination of:
    - First contact with 24 hours of receipt of referral and initial home visit within 72 hours
    - Weekly home visits for the first month
    - Visits at 2–4-week intervals
    - Weekly and monthly phone calls to reassess status
    - Community Clinic Assessment
    - Regular evaluation as to whether home visits to be extended
    - Re-evaluation is to be carried out if patient is readmitted to hospital
- Patients are to be regularly reassessed, and the amount of follow-up increased or reduced based on their clinical and psychosocial status.
- The HFN is to work towards maximising the impact of the intervention and limiting contact thereafter
- The HFN will only care for patients with a diagnosis of LVD by echo. Therefore, as mentioned above, a paper exercise will be carried out to determine the cohort of patients who have a confirmed diagnosis, what their status is, and from those, who will benefit from heart failure nursing services. The results of the review to be fed back and discussed with relevant GPs and a care plan established.

Care Pathways

Implementing a Community Heart Failure Nurse Service allows NNE and NW to continue care outside of a hospital setting. The role has been evidenced as an integral part of the pathway, contributing to a multi-disciplinary team approach and reducing the financial burden.

When a patient is identified as being in end stage heart failure, it is expected that the Community Heart Failure Nurse will link into the End-of-Life Pathway.

- **Respiratory**

Aims:

The Respiratory Service is a community focused specialist service dedicated to supporting patients suffering with chronic respiratory disease, with a predominant focus on Chronic Obstructive Pulmonary Disease (COPD). COPD is a major cause of morbidity and mortality, approximately 1 person dies every 20 minutes – approximately 25000 people a year (DH 2011).

The service is also responsible for providing reviews for individuals who have been prescribed oxygen therapy, in line with a locally agreed pathway of care. This entails developing effective working relationships with primary and secondary care to maintain a database of information relating to

recipients of oxygen therapy. This role is to encompass all adult patients receiving home oxygen, including those with non-respiratory diseases.

The service will enhance the quality of care to patients to reduce unnecessary admissions to hospital, facilitate early discharge and improve optimal medication therapies.
For this specification, it will include COPD.

Objectives:

- To proactively seek patients with COPD by working closely with GP practice teams, utilising predictive risk tools.
- To provide a domiciliary specialist nursing and physiotherapy service to people with COPD.
- To deliver integrated, co-ordinated and accessible services for patients with COPD in a cost-effective manner, as part of the virtual community ward.
- To raise awareness of evidence-based practice through the provision of training, educational programmes and supervised practice to other community-based care providers.
- To provide disease specific case-management including a robust plan of care that is developed in partnership with the multidisciplinary team, and which is appropriate to the individual's needs.
- To ensure patients and their carers are equipped with the knowledge necessary to facilitate effective self-management of their respiratory condition within the community setting, reducing the need for acute management and admissions to hospital.
- To acknowledge the palliative stage of the disease process, co-ordinating care to facilitate end of life choices, involving other members of the community ward and multi-professional team as needed.
- To establish and maintain effective channels of communication across the primary and secondary care interface and to forge strong working partnerships with external agencies supporting the patient care pathway.
- To develop and support the implementation of nurse led community-based clinics, exercise programmes and support groups such as Breath Easy Nottingham and their carers.
- To identify carers and signpost to appropriate services.
- To avoid admission to hospital, through timely and responsive, evidence-based care and optimisation of treatments.
- To provide an evidence based, comprehensive, multi-disciplinary pulmonary rehabilitation course to patients with COPD and bronchiectasis.
- To assist with secondary care early discharge programmes for patients with COPD who can be managed in a community setting with the assistance of a professional multidisciplinary care team.
- To work effectively with smoking cessation services to promote smoking cessation.
- To assist with the delivery of consultant led community-based COPD clinics.
- To provide a domiciliary home oxygen review service in conjunction with Nottingham University Hospitals to all patients registered with a Rushcliffe GP on home oxygen, in line with the agreed care pathway for oxygen therapy. This includes patients prescribed home oxygen for reasons other than respiratory conditions.
- To input and contribute to the HOS-AR portal which will maintain a database of people receiving home oxygen.
- To review the home oxygen data from the provider and act accordingly to promote concordance and compliance of home oxygen use.
- To initiate withdrawal of oxygen as appropriate and in conjunction with medical support.
- To inform the Oxygen Provider of any deaths to ensure the equipment is removed from the deceased home and charges to the ICB are stopped
- The objectives will be jointly reviewed with public health patient data, patient population need and development of the respiratory team.
- To contribute and utilise data, local intelligence and national information to inform local service improvements.
- To raise the profile of the CHP respiratory team within the ICB and Nottinghamshire.

Expected Outcomes:

There are recognised limitations in extracting data for specific cohorts of patients e.g. those with COPD confirmed on spirometry and it is therefore difficult to demonstrate that any improvement, for example, a reduction in non-elective admissions or length of stay, is directly attributable to the Respiratory Team Service (RTS).

With appropriate, timely and effective home oxygen assessments, a reduction in the annual home oxygen spend will reduce by 10% over the financial year.

The main measurable benefits of the Service will be qualitative and will include:

- Improved patient and carer satisfaction and experience
- Minimal numbers of patient and carer complaints
- Increased compliance with home oxygen and appropriate prescribing of home oxygen
- An increase in the number of patients who die in their preferred place of death
- Improved satisfaction for wider stakeholders for example, increased GP satisfaction with the consistency and accessibility of services measured against previous survey results.
- To increase the number of patients with personalised care plans.
- To increase the number of patients who have standby rescue medications in the event of an exacerbation.
- A comprehensive database of patients receiving home oxygen, including diagnosis, HOOF prescriptions, diagnosis etc.
- Data collection and co-ordination of the home oxygen service and patients receiving home oxygen, including those who do not have a primary respiratory condition.
- Provide home oxygen expert advice for patients, relatives, GP, and community colleagues.

Service Description

The clinical focus of the Service is evidence-based disease management and promotion of self-care strategies for patients predominantly with COPD. It includes reduced attendance at the Emergency Department or avoidable admissions using a case management approach and the facilitation of end-of-life care choices for patients with advanced disease.

The service will also work to extend and strengthen the knowledge base of respiratory disease management within the community setting so that the capacity to manage patients with stable COPD in primary care is increased, and to reduce hospital admissions unless admission is required for more complex management.

The team comprises of Respiratory Nurse Specialists, home oxygen nurse, clinical support workers, Physiotherapy and administrative support but with access to the wider health and social care community to provide services to promote independence and self-management as much as possible.

For Rushcliffe and Nottingham Northeast referrals are to be processed via the Rushcliffe Community Hub and to include the wider multidisciplinary team input including occupational therapy, medicines management, mental health services and community nursing as required.

Service Model

The integrated service model will include:

Level 1:

- General Practice: it is anticipated 70-80% of patients with respiratory disease will be stable and will attend their GP practice. Patients can be referred directly to the pulmonary rehab service by the GP. Members of the respiratory team will review practice registers with GPs, using risk prediction tools to determine any patients who would benefit from review to prevent possible escalation into Level 2

Level 2:

- Patients who require a medium level of case management
- Patients who have a ‘pink card’ referral initiated by the GP, community matron, secondary care or the respiratory team.

Level 3:

- Patients who are at risk of unplanned hospital admissions through exacerbation and/or who are thought to be ‘not stable’.
- Patients who require proactive medications management through anticipatory antibiotics and/ or steroids.
- Patients who require long term oxygen therapy.
- Patients with personalised care plans.

Direct patient care:

- A comprehensive assessment and care plan, based on an individual need will be implemented and supported via domiciliary visits and/or clinics.
- Care is provided via home-based visits (including residential and nursing homes), nurse-led clinics or a combination of both. Most patients will have at least one domiciliary visit with the need for further visits or clinic attendance agreed with the Nurse Specialist. Frequency of follow-up is based on the individual clinical needs of the patient.
- The patient's pharmacological management is reviewed and optimised in accordance with evidence-based guidelines and in collaboration with the patient's consultant and /or GP.
- Clinical status is regularly monitored, and appropriate laboratory parameters reviewed following changes to medication to facilitate early detection of clinical deterioration and/or adverse drug related side effects.
- Pulmonary rehabilitation provided within a suitable environment, e.g. health centre (Rushcliffe and Nottingham northeast only).
- Domiciliary Home Oxygen 4 -6-week reviews for all patients prescribed home oxygen following the initial home oxygen assessment which will be carried out by NUH Respiratory Service, or any other service who initiates (Long Term Oxygen Therapy) LTOT.
- Home oxygen reviews for patients who require a review.

Education and training:

- The emphasis of patient education is upon empowering the individual with the knowledge and skills necessary for effective self-management of their condition.
- The Service provides a specialist educational resource for other community-based care providers supporting patients with COPD and/or those who are prescribed home oxygen.

Referral Criteria and Sources

All respiratory patients referred must have spirometry, a recent chest x-ray and/or a diagnosis of respiratory disease i.e. COPD or patients who are prescribed home oxygen

Considerations for referral:

- Patients with COPD who require optimisation of therapies.
- Patients who are on maximal tolerated therapy who require disease specific education to promote effective self-management of their long-term condition.
- Patients with a history of unplanned respiratory related hospital admissions.
- Patients in whom symptoms persist or deteriorate despite treatment.
- Patients who would benefit from pulmonary rehabilitation (including bronchiectasis) (Rushcliffe and Nottingham Northeast only)
- Patients who are prescribed home oxygen excluding palliative care.

- **Pulmonary Rehabilitation Service (Nottingham West only)**

Aims:

- Provide a comprehensive Pulmonary Rehabilitation Service which forms part of an integrated team approach to delivering good COPD care to the cluster.
- To deliver improved, accessible, equitable service and health outcomes for patients using the Pulmonary Rehabilitation Services and ensure an integrated approach to both acute and chronic disease management across the Nottingham West area.
- To ensure that service delivery meets the standard requirements of the Nottingham West COPD Tiered pathway, developing pathways that will cater for prevention, diagnosis and self-management, stabilisation and specialist intervention and treatment
- To provide oxygen therapy during exercise and activities of daily living, for patients on Long Term Oxygen Therapy and completed pulmonary rehabilitation.
- To provide heart failure rehabilitation for appropriate patients in receipt of pulmonary rehabilitation.

Objectives:

- To provide care closer to the patient's home within the community to ensure that they have a safe and effective treatment that is suitable to their needs

- To ensure that patients with COPD who require access to Pulmonary Rehabilitation services receive equal access to these service
- To support Practices and Primary Care services in the management of COPD, and made aware of referral pathways into pulmonary rehabilitation, through appropriate education
- Provide clinical Leadership and coordination of the service in line with the COPD pathway
- Pulmonary Rehabilitation to be offered to all patients who consider themselves functionally disabled by COPD (usually MRC3 grade and above)
- The Pulmonary Rehabilitation programme to include multidisciplinary interventions to include, physical training, and disease education, nutritional, prevention advice and psychological and behavioural interventions
- The service will ensure Patients are aware of the benefits of pulmonary rehabilitation and self-management of the condition and level of commitment required to gain the benefits

Service Description
Nationally COPD has been singled out by the DH as a long-term condition, the treatment of which requires change to incorporate, a whole pathway approach to the delivery of service.

This will enable patients to be treated within their local community, improve their quality of life and reduce healthcare costs associated with unnecessary hospital admissions. Nationally an exacerbation of COPD accounts for 1 in 8 acute medical admissions. The total cost of COPD to the NHS is nearing one billion pounds. The majority of this is associated with emergency care.

In addition, COPD patients are known to have more than one condition, many are diagnosed with a heart condition, many patients may have two or more long term conditions, so it is vitally important the COPD pathway provides an effective link to other long term conditions and the care of COPD patients is not in isolation.

Pulmonary rehabilitation is defined as a multidisciplinary programme of care for patients with chronic respiratory impairment that is individually tailored and designed to optimise the individual's physical and social performance and autonomy.

Home visits may be considered in some cases where a patient is motivated and is judged (by clinical assessment and reasoning) to have the potential for rehabilitation but is not fit enough for the standard programme. The purpose of the visits would be to improve fitness to enable the patient to access the standard programme.

Staffing
The Service Provider will be required to provide sufficient qualified and appropriately trained staff to ensure that the specified service is provided in accordance with the Service Specification and NHS employment regulations. There is a requirement to ensure that the service is fully staffed and operational to ensure Service levels are maintained during staff holidays, or absences due to sickness, training or any other absence.

All staff providing the service will be accredited with their respective professional body e.g. Royal College of Nursing and Charted Society of Physiotherapist and there will be no concerns about clinical practice. All staff will be Criminal Records Bureau (CRB) checked and hold work permits if appropriate and be in receipt on ongoing professional development.

Following investment from national Pulmonary Rehab transformation funding starting in 2022/23, the Pulmonary rehab service will start to increase staffing to address the current waiting list backlog and increase PR capacity and target health inequalities to be able to demonstrate:

- Increased PR referral and completion rates
- PR accreditation (services to be registered for PR Accreditation by December 2022)
- Provide translated correspondence for communication on PR
- Provide the PR DVD/Virtual options in a translated and subtitled format
- Improve media and advertising in targeted communities
- Translator services within face-to-face treatment options
- Work in partnership with healthier lifestyle coaches to increase post compliance and self-management

- Working to the Nottingham and Nottinghamshire ICS (NNICS) PR 5 Year plan and MOU

Facilities and Equipment

- Activity programmes will be delivered in appropriately equipped facilities, providing the necessary equipment for the patients to perform physical activities, i.e. treadmills/cycles and equipment to support muscle strength training.
- Provider to ensure equipment is fully maintained and all clinical equipment is calibrated according to manufacturer's guidelines.
- Facilities available to deliver educational sessions to patients

Service Model

The programme will be for a period of 8 weeks (including time for pre and post assessment) with goals to reduce the symptoms and disability, to improve functional independence in people with lung disease. Training frequency should involve two supervised sessions per week. Supervised sessions should be augmented by further daily home-based sessions.

Home visits may be considered in some cases where a patient is motivated and is judged (by clinical assessment and reasoning) to have the potential for rehabilitation but is not fit enough for the standard programme. The purpose of the visits would be to improve fitness to enable the patient to access the standard programme.

The rehabilitation process incorporates a programme of physical training, disease education, and nutritional, psychological, social, and behavioural intervention.

Physical Exercise that is individually tailored to improve functional exercise capacity, reduce exertional dyspnoea, and improve health status, by incorporating:

- Aerobic physical exercise training or endurance (i.e., walking and cycling, singly or in combination)
- Isolated muscle strength training by repetition

Education that will allow patients to manage their condition more effectively. Areas to be covered include: -

- Anatomy, physiology, pathology and
- Pharmacology (including oxygen therapy)
- Dyspnoea / symptom management, chest clearance techniques
- Energy conservation / pacing
- Nutritional advice
- Managing travel
- Benefits system
- Advance directives
- Making a change plan
- Anxiety management
- Goal setting and rewards
- Relaxation
- Identifying and changing beliefs about exercise and health related behaviours
- Exacerbation management (including coping with setbacks and relapses)
- The benefits of physical exercise
- Smoking cessation
- Advanced directives – information will not be part of education session but will be available to all members. Specific details available on patient request.

The Programme must be overseen by a Band 8 Specialist Respiratory Physiotherapist. This person will be expected to proactively lead the service, promote and develop innovative ideas, work as part of the established Nottingham West multidisciplinary COPD team and help in the promotion of this service.

Staffing ratios will vary according to the characteristics of the patients, the provider will ensure all classes are adequately supervised, the ratio to be agreed with the provider with consideration of current National guidelines.

Funding for a COPD specialist nurse has been included in this specification to ensure that the delivery of pulmonary rehabilitation does not directly impact the existing COPD nursing service.

Funding has also been included to cover the recruitment of a technical instructor/support worker to ensure that the specialist nurse time is used effectively.

Integration with the existing Nottingham West COPD nursing service is essential. This will ensure that patients' needs are assessed effectively both prior to and after the programme of rehabilitation and that the patient's self-management plan is updated accordingly.

It is the Providers responsibility to ensure that working relationships and operating procedures with the existing Nottingham West COPD nursing service are agreed prior to commencement of the service.

Attendance by all members of the Pulmonary Rehabilitation team at monthly multi-disciplinary team meetings with the existing Nottingham West COPD team is essential. These meetings may also be used as an opportunity to discuss operational concerns with the integration of services.

It is recommended that the patient undertakes a course of pulmonary rehabilitation prior to assessment for Ambulatory Oxygen.

- **Diabetes Specialist Nursing (Rushcliffe and Nottingham Northeast only)**

Diabetes mellitus is a long-term condition in which the body is unable to control blood glucose levels due to an absolute lack of insulin (Type 1) or relative lack of insulin and/ or insulin resistance (Type 2). It is recognised there are two main types of diabetes mellitus – Type 1 diabetes (T1DM) which accounts for approximately 10% and Type 2 diabetes (T2DM) which accounts for approximately 90% but in addition there are other less common types.

The number of people with diabetes is increasing worldwide and, in the UK, it is projected to rise from current levels of 3.1 million to 3.8 million by 2020. One of the risk factors for T2DM is obesity and due to increasing obesity levels in the UK it is expected that the incidence of T2DM in the UK will increase because of this to an estimated number of 4.6 million by 2030.This makes it the long- term condition with the fastest rising prevalence.

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality-of-care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year. In addition, poor diabetes control and management can lead to serious life-threatening and life-limiting complications.

As an individual may also have other long-term conditions in addition to diabetes, the NHS needs to rise to the challenge of multi-morbidity through proactive and comprehensive disease management, placing the individual firmly in the centre of the care. It does, however, need to be acknowledged that not all people with diabetes have additional long-term conditions but they too require access to good quality care provision.

Whilst it is acknowledged that many of the service requirements for T1DM and T2DM will overlap – such as retinopathy, podiatry, psychological therapies etc. there are differences between the two groups and as such the service provision and delivery need to accommodate these differences. It is still generally considered that patients with poorly controlled T1DM and young adults are best managed by secondary care teams along with the other specialist groups including those with severe renal disease, foot problems, patients on insulin pumps as well as pregnancy and inpatients.

Within Rushcliffe and Nottingham Northeast, the GP practices currently choose to deliver an enhanced service for patients with type 2 diabetes at one of three levels. The majority in Rushcliffe and Nottingham Northeast deliver a Level 2 service with only 3 practices choosing to deliver a Level 1 service. There are no Level 3 practices.

The level of support that practices require from the DSN service varies according to the expertise and confidence of the practice staff but also to the number of patients with type 2 diabetes within the practice.

As the number of people with diabetes is increasing annually the Provider will need to take this into account when designing their delivery model to ensure that all outcome measures are maintained for the duration of the contract.

Previous commissioned service
Historically diabetes services were mainly delivered in secondary care clinics, especially for people requiring complex management including insulin. In 2010, a diabetes service was commissioned by the former Rushcliffe CCG (formerly Principia Partners in Care) which allowed for the avoidance of referral into secondary care clinics for insulin initiation and the transfer of patients back to GP management for those patients with T2DM on insulin therapy.

By having the support of an experienced Diabetes Specialist Nurse (DSN) and a secondary care consultant providing mentorship for the DSN, the GP practices felt adequately supported to safely deliver this service. The purpose of this service was to provide a locality based, high quality, patient centred service which was delivered by practice teams at different levels according to levels of experience and expertise within each GP practice. The service levels were agreed by each practice and the levels reflected the amount of help and support needed from the DSN.

Level 1 DSN led clinics (minimal practice involvement) to a specific cohort of patients. This is the only level where the DSN had a caseload, and patients remained the responsibility of the Provider (Nottingham University Hospitals NHS Trust).
Level 2 DSN/GP practice would deliver joint specialist diabetes clinics (sharing of responsibility between GP practice and Nottingham University Hospitals NHS Trust)) to any patient with type 2 diabetes who they felt they needed help with or required complex treatments such as amber 2 drugs (oral and injectable therapy) or insulin.
Level 3 GP practice would manage patients with type 2 diabetes on their own (minimal DSN involvement).

There was a financial remuneration for those providing either Level 2 or 3 services at a pro- rata rate for different levels and the service provided –

1. For insulin initiation
2. Management of patients with T2DM on insulin.

(No financial remuneration is given to Level 1 practices).

This service was primarily for people with T2DM but on occasions accommodated patients with T1DM. These tended to be individuals who refused to attend secondary care for their diabetes management.

Aims and Objectives

- Provide and support the delivery of high-quality care, as defined by NICE Quality Standard (Q56), to all service users
- Provide and support the delivery of a holistic approach to the management of diabetes for all service users
- Support the use of personalised care planning for each service user which will form the basis of their management and self- management.
- Empower the service user to self-manage their diabetes and encourage independence when possible and appropriate
- Contribute to helping reduce the risk of morbidity and mortality arising from diabetes by practicing evidence-based medicine
- Contribute to reducing the severity and frequency of acute episodes and helping to avoid unnecessary admissions to hospital for diabetes related problems
- Ensure that service users are referred to appropriate services as and when a specific clinical need arises
- Offer support and advice to the service user directly or through the relevant health care professional (HCP) to help with their diabetes management and achieve an improvement in glycaemic control when needed.

- Support other HCPs to provide regular and ongoing monitoring and assessment of the person with diabetes
- Provide education to HCPs as necessary to support professional development

Service description/care pathway

- The service will cover the registered population of Rushcliffe
- The service will mainly be provided within GP surgeries but can be in the patient's home if deemed more appropriate
- It is the responsibility of the provider to secure premises from which the DSN will work
- The ICB have commissioned a full time DSN for Rushcliffe. The DSN service will ultimately be delivered over 37.5 hours per week, however, due to current resources it is only possible for it to be delivered Monday to Thursday (30 hours per week). Exact working hours need to be flexible to accommodate the requirements of the practice and the service user.
- Current resources do not allow for cross cover across different Place Based Partnerships and Commissioners and the service cannot accommodate any emergency cover
- Referrals will be through the community single point of access (SPA)

Service Model

Good standards of diabetes care to be delivered by all HCP and all practices.

To optimise diabetes care to most patients with T2DM the DSN service needs to position itself within primary care and work closely with all GP practices within the South Nottinghamshire Place Based Partnership. As such the service will primarily be a practice- based service but there will be support for allied HCP within the community when necessary.

	Level 1 (Specific caseload)	Level 2 (No caseload)	Level 3 (No caseload)
Support the initial and continuing assessment and management of the service user with diabetes with sub-optimal control	The DSN would require a written referral from GP practice with a clear reason for referral. If patient is not on injectable therapies/specialist medications the patient should be discharged back to practice management once stable	The GP practice would book patient into the joint specialist diabetes clinic for a review with DSN. If practice team feel able to manage patient with support, they will take over responsibility for ongoing management	No DSN support should be required. If necessary, GP practice can discuss the case with the DSN via telephone.
Support regular care planning for each service user with diabetes. This personalised care plan should be used in all care settings that the service user attends	The practice is responsible for performing the annual review for diabetes/long term conditions. Personalised care planning should be performed as part of this yearly review.	The practice is responsible for performing the annual review for diabetes/long term conditions. Personalised care planning should be performed as part of this yearly review.	The practice is responsible for performing the annual review for diabetes/long term conditions. Personalised care planning should be performed as part of this yearly review.
A responsive service is provided that addresses practice and service			No DSN support should be routinely required unless in

user needs, provides support and demonstrates that feedback is acted upon and informs improved service delivery			exceptional circumstances. When needed telephone support should be available to the practice staff
The provider will triage all referrals following the agreed referral pathway. If the requirements of the service user are beyond the scope of the service, the provider will ensure fast track referral into the specialist pathway	Referral pathway to be clarified and criteria agreed	Referral pathway to be clarified and criteria agreed	No DSN support should be routinely required unless in exceptional circumstances. When needed telephone support should be available to the practice staff
Provide continuing diabetes education to practice staff and community staff			
Assess and support the clinical competency of staff providing diabetes care			
Provide informal education for service users in all settings to promote self- management	This forms part of the consultation and will be given as required based on patient need	This forms part of the consultation and will be given as required based on patient need	No DSN support should be routinely required unless in exceptional circumstances
Support the ICB Medicines Management team to review prescribing guidelines and practice	Regular meetings between DSN and Medicines management leads to facilitate this	Regular meetings between DSN and Medicines management leads to facilitate this	Regular meetings with practice staff and medicines management leads to facilitate this
Partake in and lead audits across all care settings, reviews data and uses it to inform and stimulate improvements in service delivery			
The provider will update GP practice systems detailing interventions and treatment plans to	The DSN will update patient record during consultation as will be using practice-based	The GP/PN will update patient record during consultation as will be using practice-	The GP/PN will update patient record during consultation as will be using practice-

ensure effective communication within primary care	system (not community model) Telephone consultations can be entered remotely onto SystmOne but not on EMIS web system	based system (not community model) Telephone consultations can be entered remotely onto SystmOne but not on EMIS web system	based system (not community model)

Ad hoc

- Signpost service users to local accredited structured education program DESMOND
- Signpost service users to other services e.g. Changepoint, Fit4Life programme
- Encourage patients to attend local retinopathy screening service
- Arrange for GP practice to refer to specialist services e.g. psychological support, foot services, pre pregnancy counselling services

Referral Criteria

- The service will be locally based with most of the care provided in GP practices across the South Nottinghamshire Place Based Partnership locality. Most patients with T2DM (with occasional T1DM) will be managed through local GP practices with the support of a DSN and consultant diabetologist.
- Patients with compliance issues or a need to consider a therapy change (which the practice feels unable to do themselves) should be referred to the DSN/joint specialist diabetes clinic.
- Patients requiring commencement of insulin therapy/non- insulin injectable therapies where the practice is not confident/competent to do this independently should be referred to the DSN/joint specialist diabetes clinic.
- Patients with complex care needs/complex medical history which the practice staff feel unable to manage themselves should be referred to the DSN/joint specialist diabetes clinic
- Patients with suspected newly diagnosed type 1 diabetes should be referred to NUH drop-in clinic/same day clinic as an urgent/emergency referral

- **Diabetes Specialist Nursing (Nottingham West)**

Diabetes is a long-term condition caused by too much glucose in the blood. There are two main types of diabetes, Type 1 diabetes and Type 2 diabetes. Ten per cent of people with diabetes have T1DM, and 90 per cent have T2DM. In addition, there are other less common forms.

Many of the service requirements for T1DM and T2DM will overlap. In other elements each disease will require discrete service provision; where the service requirements differ between the two diseases this will be made explicit in the following document.

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality-of-care provision varies throughout the country. Diabetes is a major cause of premature mortality; up to 24,000 people with diabetes are dying each year from causes that could be avoided through better management of their condition. The number of people in the UK with diabetes is increasing, in 2013 there were 3.2 million people who had been diagnosed by 2025, it is estimated that this will rise to five million people. Due to the increasing obesity levels in the UK, it is expected that the incidence of T2DM (which accounts for approximately 90% of diabetes in the UK) will increase. This makes it the long-term condition with the fastest rising prevalence. If diabetes is not managed properly it can lead to serious life-threatening and life-limiting complications, such as blindness and stroke. An individual may also have diabetes and any other number of other long-term conditions, like, for example, chronic obstructive pulmonary disease (COPD). The NHS needs to rise to the challenge of multi-morbidity through proactive and comprehensive disease management, placing the individual firmly in the centre of their care.

Aims

- Provide high quality diabetes care, as defined by NICE Quality Standard (QS6), to all Service Users
- Provide a holistic approach to the management of diabetes for all Service Users
- Through personalised care planning, empower Service Users to self-manage their own diabetes
- Deliver person-centred outcomes in a timely manner
- Provide parity of esteem between mental and physical ill health for those with diabetes by reducing rates of depression, anxiety and self-harm in Service Users with diabetes and by increasing the rates of access to psychological therapies for the 20-40% of Service Users with comorbid depression and diabetes.
- Ensure a regular (at least annually) collaborative and Service User-centred care planning session for each Service User with diabetes that forms the basis of their management and self-management. This personalised care plan should be used (and if necessary, further developed) in all care settings that the service user attends.
- Support generalist health care professionals to partake in continuing diabetes education ideally delivered by the community-based MDT and/or the specialist team.
- Provide support to the prescribing plan set by medicines management.

Objectives

- Contribute to a reduction in the complications resulting from diabetes.
- Contribute to a reduction in the number of years of life lost for service users with diabetes.
- Provide regular monitoring/assessment and provide the information and outcomes of such assessments to the service user in an understandable form
- Contribute to a reduction in the severity and frequency of acute episodes including episodes of diabetic ketoacidosis, hypoglycaemia, hyperosmolar non-ketotic state.

Service Description

- The service will cover the registered population of Nottingham West
- It is expected that the service will be supported in the patient's home and community clinics.
- It is the responsibility of the provider to secure premises from which the Community Diabetes Specialist Nurse will work.
- The nursing services are to be delivered full-time over 37.5 hours/week. Exact hours to be flexible according to meeting the cluster need and a pro-active approach to care.

Service Model

- Ensure Service Users are provided with full access to all elements of the pathway when clinically appropriate.
- Ensure clinical staff are competent, qualified and/or trained in diabetes care
- Information is provided at the time of referral to enable the Service User to make informed decisions regarding care and requirements.
- Support, information and scheduled reassessments are provided at the time of first assessment.
- On-going support is provided where required.
- A responsive service is provided which addresses Service User's needs, provides service support and demonstrates that feedback is acted on and informs improved service delivery
- A responsive service is provided that regularly partakes in audit within and across all care settings, reviews data and uses it to inform and stimulate improvements in service delivery
- Education (in addition to the formal structured education courses) for Service Users in all settings to promote self-management.
- Ensure that personalised care planning remains the mechanism of care delivery for, and interaction with, each Service User with diabetes.
- Provide a triage system for prioritising referrals
- Provide practice based education in addition to signposting to formal structured education programmes
- Provide regular monitoring and of the diabetic condition ensuring Service User engagement.
- Provide screening for diabetic foot conditions

- Provide pre-pregnancy advice for women of childbearing age in line with NICE QS7 and NICE CG63 if not provided in the GP practice.
- Provide a dedicated service to improve glycaemic control for Service Users with Type 2 diabetes whose glycaemic control is poor despite best efforts with self-management and in primary care in line with NICE CG87 and NICE TA203, NICE TA53, NICE TA248, NICE TA288, NICE TA315.
- Provide specialist Type 1 diabetes care when the MDT is supported by a Consultant Diabetologist in line with NICE CG15.
- The Provider will triage all referrals and where the requirements of a Service User are beyond the scope of the generalist team, the Provider will ensure the Service User has a fast-track referral into the specialist pathway.
- The number of people with diabetes is increasing annually and the Provider will take this into account when designing their delivery model to ensure that all outcome measures are maintained for the duration of the contact.
- Support the use of more cost-effective diabetes related products (e.g. medications, blood glucose testing strips and needles) as set within the prescribing plan.
- Signpost Service Users with diabetes to the local accredited structured education program.
- Refer Service Users with diabetes to the local retinal screening service
- Provide a dedicated service to improve glycaemic control for Service Users with Type 2 diabetes whose glycaemic control is poor despite best efforts with self-management and in primary care.

- **End of Life Specialist Nurses (Nottingham West only)**

Aims

- To increase the number of patients who can die at home if they choose to do so.
- To reduce the number of unplanned admissions and A&E attendances to secondary care at the end of life and in the final months of life.
- To support the existing specialist and generalist services supporting patients at the end of life with long term conditions; including Specialist Nurses, District Nursing, Community Matrons, GPs, Specialist Palliative Care services etc.

Objectives

- To co-ordinate care closer to the patient's home within the community to ensure that they have a safe and effective treatment that is suitable to their needs.
- To ensure that patients with long term conditions who require access to end-of-life services receive equal access to these services.
- To support Practices and Primary Care services in the management of long-term conditions, by advising on end of life services and available support through appropriate education.
- Provide clinical Leadership and coordination of the service.

Service Description

The role will expand on Long Term Conditions management services, by the addition of a Specialist Nurse specifically to support patients with long-term conditions such as COPD, Heart Failure and Diabetes.

The service will be delivered in conjunction with existing care pathways for end-of-life and for long-term conditions.

Service Model

The Specialist Nurse will co-ordinate care and will also act as a specialist resource within the health community, supporting all stages e.g. from encouraging GP practices to improve identification of patients and increasing numbers on end of life registers and advance care planning, through coordinating care between providers during the final year of life, supporting Specialist long-term conditions Nurses and District Nursing in end-of-life care, to enabling patients to stay at home in the final days of life by improving liaison between the many providers.

It is the Provider's responsibility to ensure that working relationships with existing services are agreed prior to commencement of the Service.

The community service will be available to patients with long term conditions who may be identified as nearing end of life, although the service will also assist in the identification of patients.

The Provider will be expected to provide referral guidance and develop a referral form for referrers to ensure referrals are appropriate. This will be agreed with the commissioners in advance of the service commencing.

Patients who do not meet the acceptance criteria will be excluded. Patients with long-term conditions, when their care is already being completely co-ordinated by another end-of-life service e.g. the Nottinghamshire Community Health End of Life service, will also be excluded.

Whole System Relationships
The need for adopting a whole systems approach will be required to ensure that the "big picture" of issues across a range of different interests within complex organisational environments is considered to ensure that the patient's journey is the most appropriate. This will involve:

- Identifying the various components of the whole system – typically the individual organisations and their functions – and then systematically assessing the nature of the links and relationships between each of those systems components (organisations) and considering the dynamic nature of those links.
- Recognising the benefits that can be leveraged through whole systems working and the specific risks which arise in adopting a whole systems approach – for example how the failure of one component could affect others.

Promotion and support of self-care
Individual management plans including advanced care plans should be agreed with patients and their families/carers as part of the care planning process.

Information provided to patients and carers
The Provider must ensure that information is communicated effectively to professionals, patients and the public.

Signposting arrangements between services
One of the main reasons for this service is to offer sign posting to various services to ensure that the patient has the most appropriate information to manage their care. This will involve support from outside agencies, voluntary organisations and self-help groups.

The Provider must demonstrate patient reported outcome measures, such as improved quality of life scores, satisfaction with the service and positive patient experience.