Service Specification: C
Long Term Conditions / Case Management

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

Service name	**Long Term Conditions / Case Management**
Service specification number	Service Specification: C
Population and/or geography to be served	Nottingham & Nottingham ICB
Change to (Review period)	2025 - 2027
Service description and location(s) from which it will be delivered	- Diabetes and DESMOND – Sherwood Rise Health Centre - Community Rehab & Falls – North – Bulwell Riverside / South – Clifton Cornerstone - Home Oxygen Service - Aspect House - Community Stroke Team - The Meadows Health Centre - Speech & Language Therapy The Meadows Health Centre - Integrated Respiratory Service - Aspect House - Community Matrons - Within Community Nursing PCN's - Community Nursing: - PCN 1 – Bulwell Riverside - PCN 3 – Strelley Health Centre - PCN 4 – The Mary Potter Centre - PCN 5 – Sherwood Health Centre - PCN 6 – St Ann's Valley Centre - PCN 7 – Wollaton Vale Health Centre - PCN 8 – Clifton Cornerstone - Adult Specialist Bladder & Bowel Service - Radford Health Centre

Purpose of service

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

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

Aims and objectives

Self-Care management and independence

- Provide an equitable service for patients/citizens in the community with a long term condition prior to and from the point of diagnosis

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

Prevention

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

Care Planning

- Promote and ensure patients/citizens have a well-co-ordinated care plan shared with GPs that enables them to live and die where they choose if deemed as at the end of their life
- Supporting a patient/citizen or carer and working to deliver their agreed/advanced care plan
- Supporting Primary Care to embed practices and policies of end of life care through GP Facilitator
- GP Facilitator to support the development of new clinical guidance for Primary Care and the Community.
- Lead and assist in the implementation and evaluation of ReSPECT process across Greater Nottingham
- Liaising and Supporting organisations (i.e. EMAS & NEMS) with the implementation of ReSPECT

Multi-Disciplinary working

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

Medicines Management

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

Reduction in hospital and unplanned admissions

- Reduction in the following areas: unnecessary admissions to social care, avoidable hospital admissions or re-admissions, GP appointments, secondary care, support timely discharge from hospital and avoid excess length of stay and to offer an alternative to hospital admission and move care closer to home

- For all adults, patients/citizens to maintain independence who are at risk of hospital admission from a Long Term Condition or frailty including positive experience of End of Life care

Continued Support

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

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

Prevention

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

Long Term Conditions specific

Community Nursing

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

Continence

- Provide a Continence and Urology Outreach service that is evidence-based, holistic and individual to patient assessment, treatment and management for people who have bladder and/or bowel problems (including products and home delivery service)

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

Podiatry

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

agree that the Provider undertakes a change in its capacity management to reduce the activity in line with the commissioned contract envelope. In this latter instance any costs already above the commissioned envelope incurred would be paid for, accepting no future costs would be as a result of what may be agreed to be put in place as a consequence.

Diabetes

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

Case Management

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

End of Life

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

Rehabilitation Programmes

- Aim to improve survival and reduce risk of relapse for cancer patients (see also, sub-specification N), patients with breathing difficulties due to a lung condition and/or respiratory condition, stroke patients and those with cardio vascular disease through a programme of exercise and education
- To deliver appropriate support to promote and monitor mobility and independence (this may include working with the acute sector to deliver joint clinics)
- To deliver appropriate support to improve a patients/citizens communication skills following a significant health related event or injury
- Provide time limited goal focused rehabilitation to patients/citizens identified as having a rehab need
- **Pulmonary Rehab:** Following investment from national Pulmonary Rehab transformation funding starting in 22/23, 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
- Working to the Nottingham and Nottinghamshire ICS (NNICS) PR 5 Year plan and MOU (*see Schedule 5A, Documents Relied on*)

Bone Health

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

Urogynaecology

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

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

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

Education, Information sharing, Transition

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

Working with partners

- Work in partnership with primary care psychological therapy Providers to support delivery of 'integrated IAPT' pathways. Deliver holistic assessments for patients/citizens provided by all nursing and specialist staff in order to provide the foundations of each person specifically and acknowledge physiological, psychological, sociological, developmental, spiritual and cultural needs
- Work with pre-diabetes Provider such as the NHS Diabetes Prevention Programme to identify those individuals who are at risk of diabetes
- Ensure good links with the Local Authority understanding what lifestyle services are available for citizens
- Establish links with the Carers Hub to ensure that care and support for carers is identified proactively and delivered in an integrated way
- Work with a range of stakeholders and partners to help people age well, Improve physical and mental health and quality of life for patients/citizens
- Ensure there are appropriate links with the acute sector to promote easy access to specialist acute services such as orthotics, orthoptics etc
- Ensure good links with the Local Authority for easy access to Social Workers
- Expected to work with other Providers agreeing an advance care plan to determine decision making around a patient and use appropriate document tools
- Sharing information with other emergency Providers such as NEMS and EMAS
- Be expected to link into all available community based resources in order to provide patients/citizens with the appropriate information relevant to their health needs and to strengthen access of information

Audits

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

Risk Tools

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

Assistive Technology

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

Care Planning

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

Social Value

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

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

Categories of need

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

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

Long Term Conditions breakdown

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

Service/Condition	
Frailty, Risk of hospital admission	Providing case management for complex patients, End of Life/Palliative care, Falls, Bone health, Frailty, Nutrition, Skin and Wound care, Pain Management, Symptom Control, Continence/Catheter Management
Cardiac, Heart Failure, Stroke, TIA, Support and Rehabilitation	Coronary Heart Disease, Heart Failure, Cardiac Rehabilitation, diagnosed left ventricular systolic dysfunction, IHD, Acute coronary syndrome, Cardiac Surgery, Diagnosed stable angina, high risk of Cardiovascular disease (CVD), post stroke patients
Speech & Language Therapy	Communication, Dysphagia, Swallowing, Stammer, benign voice, laryngectomies, tracheotomy
Neurology	Brain, head and spinal cord injuries, Multiple Sclerosis, Epilepsy, Motor Neurone Disease, Parkinson's, post-polio syndrome, Cerebral Palsy, Huntington's Disease, Muscular Dystrophy
Integrated Respiratory Service and Home Oxygen Service	Asthma, Bronchiectasis, COPD and Interstitial Lung Disease, Cluster Headaches
Cancer	All diagnosed cancers
Diabetes	Pre-Diabetes, Management of Type 1and2 Diabetes, Structured Education programmes, NHS Diabetes Prevention Programme and prevention of other conditions/comorbidities including Cardiovascular Disease, Stroke, Retinopathy, nephropathy and neuropathy
Podiatry	Nail, corn and callus care, ulcer and wound care, footwear/equipment assessment advice, podiatric surgery, specialist biomechanical assessment, foot health advice, palliative foot care, provision of orthoses
Falls and Bone Health	Osteoporosis, Falls, Frailty
Rehabilitation	Falls, Osteoporosis, Frailty, Neurological conditions, Cancer, Stroke, Respiratory, Speech and Language Therapy, mindfulness, end of life patients and citizens identified through evidence who would benefit from rehabilitation
Palliative Care	All conditions including frail elderly

Community Nutrition and Dietetics	Weight management, allergies, complications related to diabetes, hyperlipidemia, gastrointestinal conditions, malnutrition/nutritional support, specialist dietetic support, case management of malnutrition, dietetics management, oversight and direction of ongoing supplies of oral nutrition supplements
Continence	Bladder, bowel conditions, Urology, Gynecology, Continence Prescription Service
Other	Breast drains, Nephrostomy flushes, Doppler testing, leg ulcer clinics, administration of medication, ear syringing, stoma care

Criteria for service use (Threshold for accessing services)

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

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

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

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

Criteria for Podiatry Service (exclusion):

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

Criteria for Podiatry Service (inclusion):

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

Workforce

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

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

Acute and community based Allied Health Professionals: Speech and Language Therapists, Occupational Therapists, Dietitians and Dietitians with a special interest in Diabetes, Podiatrists and

Podiatrists with a special interest in Diabetes, Assistant Practitioners and Physiotherapists, Rehabilitation Support Staff, Stroke Therapists

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