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| **Service Specification No.** |  |
| **Service** | Neighbourhood Team |
| **Commissioner Lead** | Jeremy Budd, Director of Commissioning, NHS Barnsley Clinical Commissioning Group |
| **Provider Lead** |  |
| **Period** | 2020/22 |
| **Date of Review** | March 2021 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   **Context and future developments**  Closer integration between health and social care is a fundamental part of both national policy and of local strategy and is essential for population health management.  Effective models of integrated care have a number of common features such as chains of care, care planning, case management, co-location, innovative contractual models, disease management, integrated pathways, clinical networks, MDT, shared guidelines and protocols and virtual teams and wards.  NHS Barnsley Clinical Commissioning Group has been working as part of the Barnsley Integrated Care Partnership (ICP) and South Yorkshire and Bassetlaw Integrated Care System (ICS) to deliver a programme of service transformation that will join up services to provide seamless care to the people of Barnsley. In Barnsley we have agreed a set of design principle for integrated care –  cid:image001.jpg@01D52B72.61C2F350  A review of health and care outcomes in Barnsley shows that there are still opportunities to improve population health and wellbeing, care and quality outcomes as well as deliver financial efficiencies and experience suggests that these benefits are best delivered through service integration. Whilst there has been significant progress with health and care integration locally there is a need to accelerate the pace of change. There is growing pressure on budgets. Growth in activity, particularly non-elective hospital admissions, and cost will outstrip growth in funding unless we deliver sustainable service transformation.  Modelling based on current population demographics, incidence and prevalence or disease and service utilisation shows some of the medium to longer term challenges of improving population health and wellbeing -   * Life expectancy: continues to increase, but further increases could plateau during 2030’s unless significant health improvement measures are taken * Health of the population: years spent in poor health, including being frail, will increase at a greater rate than total life expectancy, meaning reduced healthy life expectancy * The number of deaths: these will continue to rise, with the percentage of deaths from those who are frail increasing from c.41% at present to c.47% * Service utilisation: the impact of changing population health needs on different health and care services shows increases above the growth in total population across all service types included, but particular increases in services for the frail population, for example social care   There are five key characteristics of the integrated model of care developed with partners that the CCG want to see in Barnsley –   1. Single point of access 2. Build around neighbourhood populations and assets 3. Integrated physical and mental health 4. Care management 5. Community activated, technology enabled 6. Excellent communications between health and care professionals, carers and patients (the development of the Barnsley shared care record will be an important enabler) 7. Timeliness of care – aligning the clockspeeds across the system 8. Right care, right person approach – making the most of the skills of our workforce 9. Everybody’s business. Integrated care, ‘one team’ approach.     To realise the full potential benefits of integration there is a need to shift from the current position where services are alignment to neighbourhood to truly integrated neighbourhood teams, common pathways of care, informed and activated service users, asset-based community development and population health management.  Currently the CCG separately commissions a number of different community health services whose functions will all or in part be delivered in an integrated way by NTs. These services include –   * Neighbourhood Nursing * Domiciliary Physiotherapy * End of Life * Tissue Viability * Parkinson’s Disease * Continence and Urology * Heart Failure Nurse * Epilepsy Liaison * Memory Assessment Service * Intermediate Care * Occupational Therapy * Speech and language therapy * Podiatry * Dietetics * Community Home Loans * Equipment and Adaptations   The services listed refer to the community based aspect of this care. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **🗸** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **🗸** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **🗸** | | **Domain 4** | **Ensuring people have a positive experience of care** | **🗸** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **🗸** |   **2.2 Local defined Outcomes** **Outcomes** The Barnsley Health and Wellbeing Board recently adopted an integrated care outcomes framework (ICOF). The NT service will contribute to delivery of many of these outcomes working in partnership with other services, providers and residents. The areas where the NT service will be expected to impact directly are signalled with an “X”.   |  |  |  | | --- | --- | --- | | A1. Improve health and wellbeing | Healthy life expectancy at birth (Male) | X | | Healthy life expectancy at birth (Female) | X | | Excess winter deaths (3 years, all ages) | X | | A2. Reduce health inequalities by ensuring improvement is fastest for those with greatest needs | Inequality in life expectancy at birth (Female) | X | | Inequality in life expectancy at birth (Male) | X | | Percentage of all live births at term with low birth weigh |  | | B3. People are supported to lead healthy and productive lifestyles and are protected from illness | Smoking prevalence in adults | X | | Admission episodes for alcohol-related conditions | X | | Year 6: Prevalence of overweight and obese |  | | Percentage of physically active adults | X | | Air pollution: fine particulate matter |  | | B4. Wider determinants of people’s health and wellbeing are prioritised | Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) |  | | School Readiness: the gap between the bottom 20% and the median for all other children achieving a good level of development at foundation stage |  | | Young people not in education, employment or training | X | | Social isolation: percentage of adult social care users who have as much social contact as they would like | X | | C5. People feel emotionally well and resilient | Children subject of a child protection plan with initial category of neglect: rate per 10,000 |  | | Self-reported wellbeing – high happiness score: % of respondents |  | | Suicide rate |  | | C6. People with poor mental health are better supported in the community | Average length of wait to partnership (treatment) for Child and Adolescent Mental Health Services |  | | Improving access to psychological therapies: access |  | | Hospital admissions where there was a primary diagnosis of drug related mental and behavioural disorders |  | | Mental health admissions to hospital: rate per 100,000 population |  | | D7. People receive services rated as high quality | Hospital |  | | Community and mental health services | X | | Primary medical services |  | | Adult social care |  | | Children’s social care services |  | | Percentage of care home beds (suitable for a person with dementia, aged 65+) which received an overall rating of ‘good’ or ‘outstanding’. |  | | D8. There are fewer unplanned hospital admissions and people spend less time is hospital | Inequality in unplanned admissions for chronic ambulatory care sensitive and urgent care sensitive conditions | X | | Emergency hospital admissions due to falls in people aged 65yrs and over | X | | Total hospital bed days per 1,000 registered population | X | | Total delayed transfers of care | X | | D9. People coming to an end of their lives receive services which are responsive to their needs and preferences | Percentage of people who have three or more emergency hospital admissions during the last 90 days of life | X | | The number of people on GP palliative care register per 100 people who died | X | | E10. People with long-term health and care needs  and their carers have a better quality of life | Health-related quality of life for people with a long term mental health condition |  | | Health related quality of life for people with long term conditions | X | | Health related quality of life for carer’s | X | | E11. People can manage their own health and maintain independence, wherever possible | Proportion of people who are feeling supported to self-manage their condition | X | | Proportion of people who use services who have control over their daily life | X | | Gap in employment between those with a learning disability and overall employment rate |  | | E12. People have a positive experience of work and education | Overall indicator of staff engagement (NHS Staff Survey) | X | | Proportion of council employees who would recommend it to others as a good place to work (BMBC Employee Survey) |  | | Sickness absence in the labour market (ONS data) | X | | Pupil absence in schools |  | |
| **3. Scope** |
| **3.1 Aims and objectives**  The service will provide community nursing and therapy services for patients aged 16 and over whose assessed needs are best met by community-based nursing and therapy services. This covers a wide range of patients, however an essential element of the service is to provide case management and care co-ordination that contributes to the following whole population indicators that have been identified as local priorities for Barnsley   * Reduce avoidable emergency admissions to hospitals * Reduce avoidable bed days * Reduce premature admission to long term care * Reduce admission to residential and care homes * Increase the number of patients supported at the end of life to die in their preferred place of care * Improve patient or service user experience   The expectation is that there will be a focus will be on the frail elderly and patients with multiple and complex needs and work is currently being undertaken to establish risk stratification tools that support identification of the most ‘at risk’ patients.  The provider is required to support this processes and adapt the service accordingly and work with commissioners, Barnsley Primary Care Network (PCN) and neighbourhood networks, partners, secondary care, patients and carers to develop NT services that focus on the following areas;   |  |  | | --- | --- | | **Aim 1** | **To provide timely responses and easy access to and seamless integrated care for patients with community health needs** | | Objectives | The provider is required to deliver a 24/7 single point of access and work with NHS providers and commissioners, working with Adult Social Care Leads to develop a single point of access that will be the single point of contact for NT services in the future  The provider is required to deliver services as six multidisciplinary NTs aligned to GP practice populations and the local neighbourhoods  The provider will ensure that each NT has appropriate clinical and administrative leadership and provides a named/single point of contact for all partner organisations that enables;   * direct access to the relevant NT for patients known to the service and for GP practices wishing to access case management support for identified current or potential high risk patients * access to appropriate team members for case discussion and sign posting function to a range of health and social care services across the health economy for existing patients, carers and other health and social care professionals.   The provider must ensure that each of the NTs establish and manage relationships within the neighbourhood and where appropriate Barnsley-wide to ensure providers across the health and social care economy are aware of the range of functions the NT service provides and that NT patients and carers are aware of and can access all relevant support services  The provider is required to develop transparent and trusted relationship between health and social care services across the health economy to enable more effective and efficient service delivery  The provider will enable rapid timely access for urgent referrals and a consistent response time across the service.  The service will acknowledge all referrals on receipt and advise the referrer of the response time to action the referral  The provider is required to ensure they fully understand the needs of the patient referred into the service and provide mechanisms to ensure services are built and tailored around the needs of the patient and their carers.  The provider is required to provide services in a range of community settings including residential homes, nursing and care homes, community clinics, Intermediate care facilities etc. and where appropriate co-locate services offering convenient access (at weekends and evenings where this is responsive to demand and the needs of patients)  The provider is required to develop formal joint working agreements, systems and processes  The provider is required to ensure communication and provision of simple discharge information upon discharge from the service ensuring patients, carers and the GP are aware of continued management and support needs and services and how to re-access the NT service if required | | **Aim 2** | **To provide coordinated joint care planning across organisational boundaries where appropriate to ensure patients with LTCs, End of Life (EoL) needs, and other community healthcare needs are managed effectively in the community** | | Objectives | The provider is required to ensure full integration between NTs and Primary Care. they must recognise the GP as the accountable clinician and ensure that they are involved in care planning and kept appropriately informed throughout a patients care episode with the NT  The provider is required to develop close working relationships and joint working processes with Social Care that ensure seamless delivery of integrated health and social care service  The provider is required to develop clear pathways and protocols to enable proactive efficient management of patients along a continuum of care  The provider is required to deliver a community MDT approach to care delivery to effectively plan and co-ordinate service delivery, actively seeking and encouraging involvement from GPs and relevant partners  The provider is required to work with commissioners and GP practices to develop and utilise risk stratification and profiling technology to identify and target services to those with most need in the community.  The provider is required to provide active support to GP practices in identifying, supporting and reviewing patients requiring proactive case management  The provider is required to implement proactive case management for all identified patients, this will include developing collaboratively with patients and carers where applicable a written/electronic personalised care plan, jointly owned by the patient, carer and named accountable GP and/or care co-ordinator.  The provider is required to appropriately involve/inform the GP practice of any review undertaken by a member of the integrated service and ensure care plans are updated to reflect current management.  The provider is required to deliver joint care planning/ advanced care planning for patients referred to the service ensuring plans cover the totality of the community service.  The provider is required to deliver a care navigation function where one professional has responsibility for ensuring the patient and their carers can effectively navigate the community service to ensure all needs are met effectively.  The provider is required to provide supported discharge for EoL patients wishing to die at home by providing a range of care packages across a 24 hour period.  The provider is required to facilitate patient’s preferred place of care during EoL care provision.  The provider is required to enable shared decision making to empower patients and carers, and allow increased involvement and ownership of care provision and management and to support carers to deliver care in the most appropriate setting.  The provider is required to deliver patient education and self-management as part of service delivery  The provider required to establish and utilise effective links with other health economy providers including 3rd sector links to enable holistic provision of care to patients. | | **Aim 3** | **To provide crisis intervention and care escalation to maintain patient care within the community setting where it is safe and appropriate to do so** | | Objectives | The provider is required to provide a Crisis Response including specialist function to crisis situations in all community settings (domiciliary, residential, nursing and care homes) to enable continued management of patients with the community setting and prevent admission.  The provider is required to provide a care escalation function increasing service provision to patients within the community setting as their care needs increase to enable continued management of patients with the community setting and prevent admission.  The provider is required to provide service input into step up care facilities including community intermediate care beds, respite beds and community units to ensure discharge planning is supported from admission.  The provider is required to develop formal joint working agreements, systems and processes with partner and interface services. | | **Aim 4** | **To co-ordinate and facilitate early/timely discharge to ensure patients receive care in a community setting where it is safe and appropriate to do so** | | Objectives | The provider is required to plan, co-ordinate and facilitate discharge arrangements that support patients to die in their preferred place of care.  Where a patient known to the service is admitted, the provider is required to provide a care escalation response supporting delivery of care and providing service input to enable discharge at the earliest possible opportunity.  The provider is required to work holistically and assume whole service ownership to ensure all patients’ needs are identified and addressed for transfer to the community setting to ensure successful discharge and minimise failed discharges and readmissions. The provider is required to appropriately manage risk in de-escalation of patients to the community setting utilising the support of medics and specialist clinicians to enable effective, safe and reliable discharge and coordination of services.  The provider is required to enable delivery of care closer to home and the de-escalation management of patients to the lowest possible care setting at the earliest opportunity.  The provider is required to develop close working relationships and formal joint working agreements, systems and processes with acute services and discharge facilitators | | **Aim 5** | **To use innovation to drive quality, patient experience and value for money** | | Objectives | The provider is required to implement systems to deliver joined up IT systems to enable more effective provision of care and increased communication across the service  The provider is required to actively engage with and support the development of the Barnsley Shared Care Record  The provider is required to implement systems that support remote and flexible working arrangements  The provider is required to know whether a patient has been admitted/has accessed OOH and emergency services through utilising borough-wide information and data sharing systems that are in place  The provider is required to work with partners to ensure that electronic systems are in place to actively share all patients’ personalised care plans, treatment and discharge information with GPs  The provider is required to work closely with social care to develop a single assessment framework, care plan and single care record that reduces the need for patients to tell their story numerous times  The provider is required to extensively market their service across the health economy to both health and social care professionals and the community.  The provider is required to deliver a public communications and engagement function to market their service and deliver innovative community health solutions  The provider is required to utilise innovative technology to support service delivery where this results in more efficient use of resource and empowers patients to self-manage/ monitor their condition i.e. the use of telemedicine/ Telehealth  The provider is required to actively involve service users and carers in evaluating, shaping and improving the services they use. | | **Aim 6** | **To support people to live well through better prevention** | | Objectives | To understand the local population’s health needs including the determinants of illness and poor health  To facilitate connections between different services and assets in communities including the community and voluntary sector  To adopt a principle of “making every contact count” by offering advice and signposting to support people to live healthier lifestyles for example smoking cessation, exercise and diet  Support patient activation through healthcoaching and motivational interviewing support people to take control over their health and wellbeing journeys |   **3.2 Service description/care pathway**  The section below sets out the model of integrated neighbourhood services the CCG would like to see established for Barnsley. NTs are an essential component which the CCG is directly responsible for commissioning. The diagram below demonstrates the key features of the service that include   * Services wrapped around primary care, recognising all patients registered with a practice * Access via a single point of access and referral * Integrated, seamless delivery across primary and community provision * Provision of 24/7 services where appropriate * Personalised, holistic care planning * Care and case management approach including MDT approach where appropriate     **Description**   * Care is wrapped around the patient who is at the centre of care delivery and supported by family and carers. * Adult community health services will be integrated with the six GP populations. These teams will be made up of community nursing and therapy services. * NTs will operate using a multidisciplinary approach. The teams will ensure effective engagement and communication with GPs. * All clinicians operating within the NTs are working in partnership with the patients GP and primary care colleagues * Separately adult social care services form part of the neighbourhood model. Joint working arrangements will be in place to ensure integrated care planning, co-ordination and seamless delivery across all services. * NTs provide a range of services including assessment, care planning, care coordination, case management, crisis and risk management and community nursing and therapy interventions/treatments * The NTs will be accessed via a single point of access. This will provide an initial administrative function directing referrals to the appropriate NT * Each NT will have a named clinical and administrative lead responsible for the coordination of that team’s activity and implementation of common recording systems and delivery standards across all NTs * Each NT will provide clinical triage of referrals, identifying which element of service/function or clinical discipline is required. * All community patients will have a personalised, holistic care plan that is regularly reviewed * Care provision within the model is fluid, determined by level of patient need with community care provision increasing between the low level and active/intense levels of care provision (see levels of care model below). * Case management need will be identified using agreed risk stratification tools and is envisaged to be used to support more active and intense level of care for the frail elderly and patients with multiple LTCs/complex needs   **NT pathway**  Patients known to service  Other  GPs    Referral  Infrequent contact  Intensive contact  Frequent contact  Care planning/case management  Assessment  Crisis Response  Intermediate response  URGENT/Non URGENT  Single point of access  Triage and Prioritisation  6 NTs based on GP registration  Admin triage Clinical triage  Routine response  Holistic assessment and care planning  Delivery and ongoing review  Case management need will be determined by the NT based on risk stratification, clinical complexity and discussion with referrer  **Levels of Care Provision**  The model below outlines the overall neighbourhood model and describes the relationship between NTs and wraparound borough-wide/specialist services.  Training/support provided  Joint working  Complexity  **3.3 Neighbourhood Integrated Core Team Functions**  The NTs will deliver the functions listed below -   |  | | --- | | **Administrative**   * Administrative and project support * Patient involvement champion * Neighbourhood services mapping and information contact point * Relationship development and management * Protocol development and communication systems * NT publicity and profile raising | | **Nursing**   * Primary prevention eg. Bone health * Application of compression hosiery * Assessment and review Assessment of nursing need and care planning * Bladder and bowel movement * Bowel management * Care homes service * Case management * Catheter care * Chest drain management * Intermediate Care bed support in people’s homes and in a bed base * Daily review of end stage EOL patients and monitoring of care standards * Discharge planning care package * Disconnection of chemotherapy and management of lines * Ear care * Enteral feeding * Equipment assessment, ordering and review * Eye care/prosthetic management * Falls management and care packages * Flu vaccinations * Generic LTC care and management Health and Personal care support in the home environment for continuing care eligible patients at the end of life * Medication administration, support and review * Moving and handling assessments - impaired mobility, balance and fall * Nebulisers Nutritional review * Insulin administration/ interventions care package * Investigations care package * Longer term supportive care for patients with complex needs/multiple morbidities * Pain management * Palliative care packages/palliative care for patients eligible under continuing care fast track status * Prescribing * Crisis response multi-disciplinary care packages * Referral to appropriate services * Risk assessment * Safeguarding referrals and alerts * Self-management * Short term acute care * Smoking cessation * Support for carers * Supported discharge for EOL patients to die at home * Supporting family and carers through bereavement * Tests and investigations * Tissue viability * Tracheostomy care/oral/tracheal suction * Venepuncture * Wound care, management and pressure area care | | **Therapy**   * Activities of daily living * Assessment and review * Intermediate Care bed support in people’s homes and in a bed base (respite, rehab and recuperation) * Discharge planning care package * Domiciliary post discharge support following fracture/joint replacement * Environmental equipment care package * Equipment assessment, ordering and review * Falls management and care packages * Generic LTC care and management * Medication care packages * Moving and handling assessments - impaired mobility, balance and falls * Night sitters care package * Pain management * Palliative care packages/palliative care for patients eligible under continuing care fast track status * Pharmacy technicians, aligned to neighbourhood teams, providing support with medicines management * Crisis response multi-disciplinary care packages * Referral to appropriate services * Rehabilitation in relation to chronic disease management * Risk assessment * Safeguarding referrals and alerts Self-management * Short term acute care * Specialist mobility care package * Support for carers |   **Prescribing**  The service provider is required to provide an element of Non-Medical prescribing to enable effective holistic management of patients within the community. In providing this service the provider is required to:   * Establish and update on a timely basis a Medicines Code, which will set out a framework for practice. This may include where relevant Patient Specific Directives or Patient Group Directives. * Ensure clinicians prescribe only within their sphere of competence * Liaise closely with the patients GP regarding provision of information, future recommendations for ongoing care and when it is appropriate to discontinue medication.   **System Support**  The provider will operate as an effective part of the Barnsley health and care system and is required to work collaboratively with partners to provide flexible and responsive support during system pressures.  **3.4 Population covered**  The service provided shall be for adult patients who are registered or temporarily registered with a practice that is part of NHS Barnsley CCG. The provider must ensure that the service is equitably provided across Barnsley, in response to need, particularly in relation to the allocation of resources to ensure that patients have equal access to services which are comparable in terms of quality and responsiveness.  The service will assess all patients within a practice G.P population. Where a complex packages of care is required and the patient is not a resident in the Barnsley district, long standing agreements with neighbouring providers of community services may be acted upon for the day to day delivery of care.  Boundaries  This service is commissioned on a Barnsley registered population basis in line with “Who Pays? Determining responsibility for payments to providers” guidance published 12th August 2013. The provider has full responsibility for the delivery of this service to all Barnsley registered patients in line with General Condition 12 of the NHS standard contract. If a patient is resident outside of the Barnsley footprint but registered with a Barnsley GP, it is the responsibility of the provider to ensure services are delivered in line with this specification to that patient. However, in areas where mutually beneficial agreements can be put in place with providers that cover neighbouring CCG’s that are not detrimental to the patients care or safety permitted sub-contracts will be considered by the CCG in line with General Condition 12. **Any acceptance and exclusion criteria and thresholds**  **Acceptance**   * The neighbourhood integrated core teams provide a borough-wide community nursing and therapy service covering all patients with an assessed need where the nature of the intervention is best suited to the home or community environment * The patient is registered with a Barnsley GP or living within Barnsley Metropolitan Borough boundaries and not registered with a GP * the patient is 16 years of age or older (**to be agreed**) * (Where necessary, the integrated core teams will liaise with children’s services to facilitate a child’s transition from children’s services to adult services)   **Exclusion**   * Patients under 16 years of age * Patients who would not have difficulty attending an outpatient/community clinic or GP practice if this is the appropriate environment to meet their assessed need at that time (it is possible that a shared care plan may be in place where elements of care may be delivered in an outpatient/community clinic, GP practice and by the integrated core team in the home/community setting) * Patients for whom an alternative service would be more appropriate   **Response Times (Clockspeed)**  All decisions will be based on risk and clinical need and be clearly communicated to the referrer by the assessing clinician. The primary route for all crisis response and new referrals will be via the single point of access. NT clinicians will undertake clinical triage for referrals direct to the NT and determine the appropriate response time as appropriate to clinical need. As NTs develop we anticipate that there will be increasing communication between primary and community care facilitating joint working to support patient’s needs.   |  |  | | --- | --- | | Crisis | 2 hours\* | | Reablement | 2 days\* | | Intermediate Response | TBC – subject to consideration of referral being addressed | | Routine | TBC – subject to consideration of referral being addressed |   \* (Ian Dodge, National Director or Strategy and Innovation, NHSE and NHSI *- Implementing the Long Term Plan in primary and community services* – 27 June 2019)  **Clinical Pathways supporting the model**  The delivery of the new national service specifications and additional redesigned clinical pathways in disease specific areas will be incorporated into this specification as they are developed. Providers must configure their services to enable delivery of all elements of community care. **Operating Hours**  The Single Point of Access will operate 24/7 365 days a year service in order to support a range of response times based on patient need.  It is expected that the core team will work:   * Core 08.00 – 22.00 Mon –Sun * Night Service 22.00-08.00 Mon - Sun   Staffing levels and skill mix will be adjusted to reflect patient need. Therapy interventions will be routinely delivered during the day time hours (0800-1800) with flexibility to respond to patient need at other times.  **3.7 Interdependence with other services/providers**  Organisational Interdependencies   * Primary Care Enhanced Services eg Out of Hours * Out of scope services – community elements eg, Breathe and Diabetes * Secondary Care Services * Pharmacy * 0-19 * Social Prescribing * Care Homes * Voluntary / Private sector * BMBC Social Care * Housing services * Prevention services * Hospice   Service Interdependencies   * Stroke * IAPT * Phys Dis Neuro * Community Home Loans * Equipment and Adaptations * Health Integration (Children) * ASD / ADHD * LD * Adult MH * Children's MH * Psychology * Paediatric Epilepsy * Paediatric Audiology * Adults and Childrens CHC * Paediatric diabetes * Assisted Living * BMBC Commissioned services   **3.8 Sub-contractors**  The provider shall inform NHS Barnsley CCG of any intention to sub-contract part or all of the service specified. |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (e.g. NICE)**  The service will work to at least the following policy and guidance documents, each as amended and replaced from time to time:   * Health & Social Care Act 2008; * Care Quality Commission Registration Requirements; * National & local Safeguarding guidance, policies & procedures; * Royal College of Nursing Guidelines; * NMC Codes of Conduct and professional guidelines and standards; * Department of Health Guidance; * National Services Frameworks, where applicable i.e. Older people; * The current Operating & Outcomes framework for the NHS in England; * NICE Guidance; * National Good Practice; * Mental Capacity Act 2005; * Contemporary legislation and contemporary local and national guidance.   **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**  The service will require ongoing development in accordance with the following policy and guidance publications:   * Five Year Forward View (NHS England, October 2014); * Framework for Commissioning Community Nursing (2015) NHS England; * QNI/QNIS Voluntary Standards for District Nurse Education and Practice (2015) QNI; * District Nursing and General Practice Nursing Service Education and Career Framework (2015) NHS Health Education England; * Commissioning Better Community Services for NHS Patients (2015) Monitor; * Compassion in Practice (2012) NHS England; * Common Core Principles for Dementia (2011) (Skills for Care and Skills for Health); * Common Core Principles for Dignity (2013) (Skills for Care); * Avoiding Crisis Admissions to Hospital (2013) SCIE; * NHS The Operating Framework (2014/15); * Public Health Outcomes Framework (2013-2016) DH; * ASC Outcomes Framework (2015-2016) DH * Health and Social Care Act (2012); * Our Health, Our Care, Our Say (2006); * High Quality Care For All, Darzi report (2008); * Delivering Care Closer to Home: meeting the Challenge (2008). * Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 (2015) National Palliative and End of Life Care Partnership.   This guidance is not an exhaustive list, providers will be expected to work to new and emerging policy guidance, including that which related to and links to the delivery of community nursing and therapeutic services.  **4.3 Applicable local standards**  The provider must be able to evidence:   * That they have plans for, or evidence of, Continual Professional Development in this area of work; |
| **5. Applicable quality requirements** |
| 5. Applicable quality requirements and CQUIN goals  5.1 Applicable quality requirements (See Schedule 4 Parts A-D)  The following quality requirements will be applicable to this service:  Registration and Assurance  Professional standards will be maintained at all times in line with the NMC code of conduct.  5.2 Applicable CQUIN goals (See Schedule 4 Part E)  Outcome measures to be developed in partnership for inclusion from Q2 (2016/17) but to include/ consider:   * To facilitate supported discharge from acute providers; * Delivery of patients centred care through integrated working with health and social care providers including participation in primary care MDT meetings for patients with complex needs; * Increased awareness on the part of patients and their carers of health improvement opportunities including prevention and self-care and confidence to self-manage; * Improved access to community nursing services; * Improved quality and continuity of care. |
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| 6. Location of Provider Premises  The Provider’s Premises are located at:  The service will be provided from community bases, LIFT buildings and Primary Care locations, across Barnsley and also in the patient’s own home. Premises used by the service Provider will be fit for purpose. Premises must meet the requirements of the Health and Safety at Work Act (1974) and the Disability Discrimination Act (1995)  The Provider must ensure that the Service delivers consistent outcomes for Patients regardless of:   * Gender; * Race; * Age; * Ethnicity; * Education; * Disability (including access and regress); * Sexual orientation.   The Provider must be compliant with all relevant disability discrimination and equality legislation including the Disability Discrimination Act 1995. |
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