SERVICE SPECIFICATION

<table>
<thead>
<tr>
<th>Service</th>
<th>NEIGHBOURHOOD CARE TEAM</th>
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<tbody>
<tr>
<td>Commissioner Lead</td>
<td>KAREN RICHARDSON</td>
</tr>
<tr>
<td>Provider Lead</td>
<td>JO EVANS</td>
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<td>Period</td>
<td>2009/10</td>
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1. Purpose

1.1 Aims
The aim of the Neighbourhood Care Teams (NCTs) is to provide multi-disciplinary, seamless care closer to a patient’s home, reducing avoidable admission to hospital and facilitating discharge.

1.2 Evidence Base
The White Paper ‘Our health, our care, our say: a new direction for community services’ describes opportunities to provide care differently, out of hospital, in communities and people’s homes, where they can access safe and convenient care. This, in addition to the Intermediate Care guidance (DH 2001) and National Service Frameworks (e.g. NSF - Older People (DH 2001a), NSF – Long term Conditions), has been used to provide direction in the development of service models.

National evidence available on Intermediate Care Services, particularly NCT models across the country, especially rural areas, has been used to inform the development of the NCT model. This includes initiatives from Kennet and North Wiltshire, West Wiltshire, East Devon, West Sussex and Ealing PCTs.

Implementation of the NCTs is a key element of the PCT’s Community Service Strategy (CSS), an integrated change programme aimed at improving community services in the East Riding of Yorkshire. The Strategy aims to ensure the best possible community services care for the residents of East Riding of Yorkshire, whilst reducing the need for patients to be cared for within the acute setting. A major element of this is unscheduled care, comprising urgent care, preventive medicine, palliative and end of life care with the aim being to move away from reactive care based in acute systems, towards a systematic, patient centred approach.

The NCT service will ensure that care is delivered in line with the latest Department of Health policies, including NSFs and NICE guidance.

1.3 General Overview
The East Riding of Yorkshire is served by the largest unitary authority by land area in England (an area of 930 square miles) and by population it is the second largest non-metropolitan district in England. It is largely a rural area with over half of the population living in the countryside. The age structure shows a relatively large number of older people, while the proportion of the population aged 20 to 34 is considerably lower than the average for England.

Population predictions suggest an overall increase over the coming five years from 336,700 to 354,200. Predictions suggest a particular increase among older people (currently 62,762 are over 65
years old and 16,778 are over 80). This will give rise to an increase in the number of people who will need to access community care for rehabilitation or support to enable them to remain in their place of residence and avoid unnecessary hospital admissions.

To meet this increasing demand within the rural context of the East Riding, the NCT model has been developed as a key element of the PCT’s Community Service Strategy (CSS). The NCTs work closely with GP practices, social services and other agencies providing care. Each of the NCTs will be centred on a locality, working closely with the locality GP Practices. Within each locality the NCT will work across professional boundaries and incorporate multidisciplinary team working, with effective integrated working across health and social care. The vision is for a single point of access, with all referrals (from GPs, Accident and Emergency departments, Minor Injury units, the Out of Hours service, Ambulance service and Community Matrons) triaged and passed on to the appropriate Neighbourhood Care Team.

1.4 Objectives

- Implementation of a Neighbourhood Care Team (NCT) model of ambulatory care across the East Riding delivering quality care closer to home for patients
- Delivery of the agreed NCT pathway of care to ensure seamless, risk managed care, with reduced duplication of assessment, diagnostics and the sharing of information
- Increased integrated working between Neighbourhood Care Teams to deliver the NCT pathway of care
- Through the NCT, provision of a fully skilled multi-disciplinary community team, with a competency based training package to ensure staff have the required knowledge and skills to deliver safe and effective ambulatory care practice, in the context of evidence base practice
- Delivery of robust clinical outcomes and high levels of patient satisfaction
- Increase the prevention of unnecessary admissions to hospital of patients in crisis, who could be safely looked after at home with support.
- Increase the timely discharge of patients from hospital who no longer require acute medical intervention
- Implementation of a robust system to measure the performance of the NCT at a locality level and meet commissioner performance monitoring requirements
- Accurate recording of patient outcomes to show improvement in patient quality of life following the involvement of the team
- Work towards developing the capability to share patient level data with Social Services via a single IT system, using a collaborative approach with the Local Authority

1.5 Expected Outcomes

- Improved access to services that support patients through delivering seamless care and services at the appropriate time, place and by the most appropriate professional(s).
Patients able to proactively access services, are more in control and less likely to need acute care settings.

- Reduced A&E attendances, unscheduled hospital admissions, outpatients visits and length of stay through the delivery of convenient and responsive access to care closer to the point of need.

- Enhanced level of clinical outcome for individuals through the implementation of seamless, risk managed pathways of care, reduced duplication of assessment, diagnostics and the sharing of information, facilitating the delivery of efficient and effective services.

- Enhanced patient and carer experience, satisfaction and quality of life both through being healthier and spending less time in hospital; this by delivering preventative and proactive approaches focused on providing individuals with the knowledge and skills to facilitate self-care, well-being and promote independence.

- Patients at risk or with an increased risk score are identified and proactively case managed with appropriate interventions to maintain their care within a community-based setting

2. Scope

2.1 Service Description

This specification is for the service funded by NHS East Riding of Yorkshire and forms the detail of outcomes and activity to be delivered by the service from April 2010. The NCTs form part of the network delivering integrated unscheduled care across the East Riding in line with the PCT’s Community Services Strategy. The NCT service specification covers the core NCT outcomes with sub-service specifications, as an appendix, providing more detail regarding individual services elements within core NCT provision.

Neighbourhood Care Teams (NCTs) offer multi-disciplinary, seamless care closer to a patient’s home. They provide a service for patients in a variety of settings, primarily the persons own home but delivering some interventions in other locations such as GP practices or Primary Care Centres. Registered care homes will be managed as if they are the patient’s own home.

The Team comprises multi-professional, multidisciplinary and multi-agency professionals working flexibly across the specific locality covered by the Team.

The core Team includes the following Health and Social Care staff:
- Community Physiotherapists
- Occupational Therapists
- Community Matrons
- District Nursing staff
- Community Nursing staff (including intermediate care)
- Local Authority staff – Assessment Officers, Care Coordinators, Community Support Workers
- Community Hospital wards staff
The core NCT will deliver services in accordance with and to deliver the outcomes stated in the NCT service specification and the relevant sub-specifications detailed in Appendix 4.

The extended Team will include input from the following staff:

- Specialist Nurses including (though not limited to):
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Palliative Care and End of Life care - Macmillan specialist nurses
  - Diabetes
  - Tissue Viability
  - Cardiac Rehab
  - Bladder and Bowel health
  - Infection Control
- Staff within Community Equipment Service
- Specialised Occupational Therapists
- Dieticians
- Speech & Language Therapists
- Podiatrists
- Locality Pharmacy Service
- Out of Hours GPs and Nursing staff
- Independent Sector beds staff
- GPs and Primary Care Teams
- NHS Direct

The make up and numbers of staff within the Teams will vary across geographic clusters to meet the particular health needs of each locality and allow maximum flexibility in resource allocation.

2.2 Accessibility/acceptability

The service is expected to ensure that it responds to age, culture, disability and gender sensitive issues (this is not an exhaustive list). The provider will ensure the service delivered is acceptable to patients, staff and commissioners, by means of this specification. The service will be provided in the patient's place of residence or alternative venue(s) as appropriate and that are determined to be 'fit for purpose'. The days and hours of service will reflect the needs of the patients, waiting times targets and the minimum core hours of service (see 4.3).

The provider is expected to work in partnership with the commissioner, GPs and Primary Care Teams to implement the NCT model in line with the service specification and ensure access across all localities of the East Riding.

2.3 Whole System Relationships

The provider will ensure that the NCT service model incorporates integrated working with other community and unscheduled care services, including but not limited to:

- Out of Hours
- Minor Injuries
- Marie Curie
- GPs and Primary Care Teams
- Yorkshire Ambulance Trust
- Social Services
- Voluntary sector organisations
Strong partnership working is expected with other statutory, voluntary and private agencies to deliver seamless and continuing healthcare within community settings. Effective relationships are expected to be established and maintained between the Provider and key stakeholders including but not limited to:

- NHS East Riding of Yorkshire Commissioners
- East Riding of Yorkshire Council
- Hull and East Yorkshire Hospitals
- North Lincolnshire and Goole Acute Trust
- Scarborough and North Yorkshire Hospitals
- York Hospitals Acute Trust
- Humber Mental Health Trust

It is expected that the NCTs will be delivered as a partnership between Health & Social Services and provide an integrated service. NCTs will work collaboratively with social services to ensure there is clarity about respective responsibilities and operational arrangements for delegating tasks/functions between agencies. This will ensure care is provided in a coordinated, cost effective way.

To maximize clear communication between partners and the efficiency of services it is essential that joint care plans are established. This will involve attending multi-disciplinary meetings on a planned basis.

2.4 Interdependencies
Interdependencies will vary, reflected in partnership working requirements as identified in 2.3 and depending on the individual needs of localities and stakeholder interests. The Provider will ensure NCT provision takes account of the dependencies for each locality.

Access to and integrated working with other social care, community and unscheduled care services is required for delivery of the NCT model and the Provider will ensure the NCT delivery reflects this dependency. This includes the use of community beds (see 3.2).

2.5 Relevant networks and screening programmes
The Provider is expected to provide information to national networks as appropriate. The Provider is expected to provide support, expert opinion and information to relevant local networks, including but not limited to:
- Unscheduled Care Network
- The Stroke Network
- The Cardiac Network
- The Palliative Care and Cancer Networks

2.6 Sub-contractors
It is not expected that sub-contracting will be required in relation to NCT provision. Should sub-contracting be required, this will be in agreement with the Commissioner and the Provider will ensure that full information regarding sub-contracting arrangements is provided to commissioners for population within the NHS Contract for Community Services – Schedule 10 – Provider Sub-Contractors.

3. Service Delivery
3.1 Service model
The Neighbourhood Care Team clinical model for managed care, urgent care and rehabilitation offers a range of responses that health and social care services will provide to people who require advice, care, treatment and diagnosis (see Appendix 1). The focus of the NCT service is to prevent avoidable admissions to an acute hospital where a patient can be looked after safely at home and the provision of care closer to home including proactive case management and facilitating self-care.

This model offers consistent and rigorous assessment of the urgency of the individual’s care need and an appropriate response to that need. The name of the responding team or service may change depending on the time of day but each team will include multi professional, multidisciplinary and multi-agency professionals, linked together through integrated and shared information systems ensuring a smooth transition for the service user. The Provider will ensure attendance as necessary at multi-disciplinary team meetings to deliver a seamless service with a proactive and effective approach to case management.

The Provider will ensure that NCT provision delivers the clinical model through the following elements of care shown in Figure 1 and described below:

**Figure 1: NCT Elements of care provided**

3.1.1 Managed care
The managed care element will deliver services closer to home, based on the principle of NCTs. This will include all forms of proactive (actively seek out) and routine generic case management delivered in the 'in hours period' by GP’s, practice nurses, district nurses,
community nurses and community matrons with input as appropriate from assessment officers, specialist nurses, therapists and rehabilitation assistants.

3.1.2 Proactive case management
The Provider will ensure proactive case management by the Community Matrons of individuals at risk of a readmission to hospital, through use of a risk stratification case finding tool. Using the tool, cases at risk will be identified by the GP and other clinicians in the NCT. A multi-disciplinary discussion, including the GP, will take place and where it is agreed individuals are at risk, a senior professional will arrange an assessment visit. The purpose of this is to agree with the individual a planned ‘shared care’ approach which stabilises the individual’s condition and prevents further unnecessary admissions and/or supports earlier discharge. Management of the patient will include designation of a case manager who will co-ordinate the provision of care. The case manager will be the most appropriate health or social care professional depending on the patient’s assessed clinical needs.

Staff will work closely with specialist services and Social Care, as required for additional support, advice and skills. If care is required in the out of hours period the NCT will hand over the care to the most appropriate unplanned care service.

3.1.3 Unplanned and managed care in the form of intermediate care
Through the managed care and rehabilitation element of the service, the provider will ensure NCTs work with people to achieve their optimum potential and maintain them in their own home or residence of choice. This service element will facilitate the delivery of all forms of intermediate care, providing an interface between primary and secondary care. Rehabilitation assistants will be core members of this service element but will work closely with the rest of the team to provide health and home care as and when required.

The patients who are the focus of this care include those who:

- require further rehabilitation following an acute medical or surgical episode;
- require further rehabilitation following a fall, once their medical treatment is in place;
- present with non complex infection, such as, as a urinary tract, chest or skin infection, needing additional support during the recovery process;
- have long term conditions such as stroke, Multiple Sclerosis, Parkinsonism, head injuries, obstructive airways problems requiring additional support or rehabilitation.

In all cases each individual will be assessed and their care will be tailored to meet their individual needs.

3.1.4 Unplanned care in the form of urgent care (includes crisis intervention)
This service consists of the existing ‘out of hours’ (OOH’s) service, including First Contact Practitioners (FPCs) (qualified senior clinicians with additional training and skills in advanced assessment, diagnosis and treatment skills) and GP’s, in addition to Minor Injury Services and Urgent Care interventions delivered through the NCT. In the ‘in hours’ period the Urgent Care element of the NCT will work closely with the relevant health and social care professionals to ensure access to services by patients who need support from these service elements to maintain them safely in their own homes.
The types of response will include:

- telephone advice, providing self-care advice, re-assurance and signposting to other services
- face-to-face consultation, including self-care advice, with a clinician at home or in a community based setting
- ‘crisis response ’ through the urgent care element of the NCT
- admission to a hospital in an emergency requiring specialised services

Wherever clinically safe, care will be delivered as close to home as possible.

The key objective of the unplanned care element of the NCT service is preventing avoidable admissions to an acute hospital where a patient can be looked after safely at home. Through prevent admission support, the NCT will provide a multi-agency response and assessment for patient/users to enable them in a time of crisis to remain in their own home instead of being admitted to hospital, providing an alternative to hospitalisation and reducing hospital admissions.

To achieve a prevent admission, the patient/user must be medically stable to remain at home. Their medical needs will be at a level that can be met by their own GP. The available resources (human & equipment) must be adequate to ensure that it is safe for that person to remain at home.

The agreed definition of a prevent admission (for data collection purposes) is:

*The provision of Neighbourhood Care Team response within a timescale of 4 hours, between the hours of 8.30am and 11pm, without which an acute hospital admission or an accident and emergency/MIU attendance would occur.*

*In order for a prevent admission to be achieved, the patient should not be admitted to an acute hospital or accident and emergency/MIU department within 24 hrs following first contact.*

*For clarity, a patient who is already in the AAU/Short Stay Ward at the time of referral will still be defined as a Prevent Admission if their needs can be appropriately met within the Primary Care Setting within 48 hours of their attendance.*

3.1.5 Facilitated discharge from acute care to intermediate care

This element of NCT care assists patients who are medically stable in an acute setting, by providing a short-term rehabilitation intervention designed to enable a timely coordinated discharge from hospital. The objective is to improve an individual’s level of independence, help build confidence and to re-equip them with the skills to remain in the community. This is appropriate for people who are in hospital and can continue to regain their independence in the community (e.g. fractured neck of femur).
This element of NCT provision will also support the transition of an individual from residential care to home, by offering a short period of rehabilitation to enable them to regain sufficient physical functioning and confidence to return safely to their own home.

The objective is to facilitate early discharge from hospital and reduce delayed hospital discharges. This may require step down to a community hospital bed. The NCT will work with Community Ward staff and Social Care, as appropriate, to facilitate early discharge from hospital to an individual’s home (or place of residence).

The agreed definition of delayed discharge (for data collection purposes) is:

A delayed discharge is experienced by an inpatient who is clinically ready to move to a more appropriate care setting but is prevented from doing so for various reasons. The next stage of care covers all appropriate destinations within and outwith the NHS (patient’s home, nursing home etc). The date on which the patient is clinically ready to move on to the next stage of care is the ready for discharge date which is determined when the patient is medically stable and their social and psychological needs are able to be met. This should occur in consultation with all agencies involved in the planning of the patients discharge, both NHS and non-NHS.

Thus the patient is ready for discharge, but the discharge is delayed due to:

- Social Care Reasons
- Healthcare Reasons
- Patient/Carer/Family-related reasons.

An inpatient can be defined as a patient who occupies a bed within an acute/community hospital, nursing home, residential home or a more specific unit.

3.2 Care Pathways

The NCT care pathway offers appropriate care and prevention of avoidable hospital admissions for patients who access the NCT, as shown in the model of care:
The NCTs will be expected to utilise relevant care pathways to deliver integrated care, including but not limited to:
- Falls pathway
- Diversionary pathways
- Community bed pathway (step up/step down)

The NCT pathway forms a key part of the integrated unscheduled care model shown in Appendix 1.

Working collaboratively with Social Services, GPs and Primary Care Teams, the provider will ensure consistency in the application of care pathways across all NCTs and deliver the NCTs as part of the
wider integrated unscheduled care model. NCTs will access Community Hospital and Independent/Private sector beds (see 2.4) in line with the community beds commissioning specifications. Community beds will be accessed for step up and step down care for individuals who need sub-acute, rehabilitation or palliative care that cannot be delivered in their home.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries
The service is provided for the entire registered population of the East Riding.

4.2 Location(s) of Service Delivery
The service provided will cover the East Riding through NCT provision in each of the following geographic localities:
- Bridlington
- Driffield
- Beverley
- Holderness (Withernsea & Hornsea)
- Haltemprice
- Goole, Howden
- West Wolds

The service will be provided in the patient’s place of residence or alternative venue(s) as appropriate and that are determined to be ‘fit for purpose’.

4.3 Days/Hours of operation
The NCT service will form a core part of the 24 hour, seven day per week care delivered through integrated working with social services and other unscheduled care services in line with the integrated unscheduled care model. This requires integrated working within the NCT and with other services, including but not limited to:
- Urgent Care element of NCTs
- Out of Hours
- Minor Injuries
- Marie Curie
- GPs and Primary Care Teams

NCT service provision is expected to be: Monday to Friday between 8.30am and 11.00pm. The core NCT will be expected to deliver the service between 8.30am and 8pm, with provision between 8pm and 11pm delivered either by the NCT or other evening/OOH services (ensuring seamless service delivery to patients). Further flexibility in the core hours of NCT operation may be required to meet the needs of the locality and in agreement with the Commissioner.

Saturday and Sunday provision to be agreed with commissioner and subject to contract variation.

The Provider will ensure seamless care is delivered through integrated care pathways and integrated working between NCTs and services provided out of hours (see 2.3 and 2.4).

4.4 Referral criteria & sources
It is not possible to produce a definitive list of patients or types of presenting conditions but, as a
guide, the NCT’s will support 4 kinds of patients:

- Patients needing urgent or intermediate care
- Patients needing support in managing their own care
- Elderly and frail patients that need some co-ordinated multi disciplinary assessment and intervention
- Patients needing palliative care

The Provider will ensure all patients presenting with a healthcare need that is appropriate for NCT intervention are accepted for assessment and triage. Access to the Service will be through a single point based upon explicit and specific referral criteria (that has been approved by the Commissioner) and promoted to referral sources in Primary, Community and Secondary care. Referrals (using the criteria) will be received from an agreed range of sources including:

- Self referral (if known to the service)
- Community services
- Acute services
- Out of Hours Service
- GP or Practice
- Carer or relative
- Social Services
- Specialist Nursing
- Care Home
- Intermediate Care
- Hospice
- Therapy staff
- Ambulance service
- Mental Health services

Referrals for Intermediate Care are for time limited support (usually up to six weeks), mainly to avoid unnecessary or prolonged hospital admission or to facilitate rehabilitation following hospital discharge.

Appropriate referrals are adults who have a long term condition causing a moderate to significant decrease in functional ability; vulnerable older people with decreased functional ability and vulnerable adults and older people recovering from an operation or illness.

The key element as to whether or not a patient from the above group meets the criteria for the NCT service is the assessed level of risk of further deterioration without prompt and timely intervention or an indication that an improvement in function could be achieved thus reducing dependency on care and promoting independence and timely discharge from hospital. This will be determined through clinical assessment.

Appropriate referrals for nursing care are where the needs of the patient are best met by the NCT nursing service; home visits are made to housebound patients. (See Nursing service sub-specification – Appendix 2). NCT nurses will sign-post to other services if necessary. Where the patient is not housebound, services should be delivered within the GP surgery or locality based clinics.

The service will accept referral for all patients regardless of culture, disability, and gender sensitive issues. The service is available to over 18’s only.

4.5 Referral route

Patients who require care but are not acutely ill will be able to access NCT care. Referrals will be accepted by the single point of referral for the individual locality NCT (or the NCT single point of
access when established). Referrals will be accepted by the most appropriate NCT healthcare professional; this may include but is not limited to:

- Community Matrons
- Staff within District Nursing
- Staff within Community Nursing, including Intermediate Care
- Physiotherapists
- Occupational Therapists
- Local Authority staff

The service will (where necessary) return to the referring clinician any referral that does not meet the explicit and specific referral criteria and/or is not sufficiently comprehensive to determine this.

The service will (where necessary) facilitate access to specialist services as an onward referral.

4.6 Exclusion criteria

Patients who require acute care or who do not meet the criteria specified in section 4.4.

4.7 Response time, detail and prioritisation

All referrals will be collated via a single referral telephone number for each locality. The single referral telephone number will be answered at all times during NCT operational hours (as specified in section 4.3). Clinical triage will be accessible following receipt of a telephone referral by the locality single referral telephone number. The Provider will ensure all referral sources are aware of and have access to the single referral telephone number for the relevant locality. An audit to determine the level of inappropriate referrals will form part of the performance framework. The Provider will support work undertaken by the Commissioner to develop a single point of access for all referrals to the NCTs.

All urgent referrals will be telephoned and clinically triaged within 4 hours of receipt of referral. All routine referrals to be telephoned and clinically triaged within 1 working day.

Clinical triage will indicate if the patient is appropriate for the NCT and indicate which pathway of care is preferred. The Provider will ensure that, wherever possible, prioritisation of patients is in line with the following:

- an acute admission is avoided
- an early discharge is facilitated
- community bed access is achieved if required
- patients with palliative and end of life care needs are supported and able to die in their preferred place of death

4.8 Record keeping and communication

The Provider will use SystmOne for the recording of clinical records. All NCT clinicians will collate data on SystmOne in accordance with the agreed minimum data set outlined in the NCT service specification.

The Provider NCT staff will participate in all multi-disciplinary meetings to discuss individual patients.

5. Discharge Criteria & Planning

Discussions with the patient around discharge planning begins at the commencement of treatment and continues throughout the episode of care. Care Plans which include discharge planning are
(utilised throughout treatment.

Once the treatment programme has been completed patient discharge will take place, or the patient may be referred on to another agency. Discharge will be achieved as per the NCT operational policy approved by the Commissioner. The Provider will ensure the NCT service works closely with both acute and community bed staff, through established policies, criteria and processes, to ensure early supported discharge.

The Provider will ensure:
- discharge takes into account the needs of the patient, their family and carer/s
- a proactive approach to discharge to avoid delayed discharges, including expected date of discharge being identified on admission
- a robust discharge policy is in place and available to all NCT staff to ensure best and consistent practice
- discharge letters are sent to the patient’s GP within 24hrs of the patients discharge
- early supported discharge is achieved

6. Self-Care and Patient and Carer Information

6.1 The Provider will ensure that:
- self-care and self management of the patient’s condition is a key focus of the NCT intervention
- relevant information will be provided as required in a format accessible for the individual patient to facilitate knowledge and understanding of their condition enabling them to make informed choices for care and treatment
- appropriate support is given to both patients and carers to facilitate and promote self care/management
- user and carer involvement in the planning, delivery of care and services will be promoted
- all patients have an individual care plan with a patient prospectus (including information prescription) included as part of the Plan
- all patients will be provided with patient held records which includes their care plan
- all appropriate patients are given the opportunity to access appropriate self-management training such as an Expert Patient programme
- in addition to the individual care plan, the patient and carer/s will be given clear information regarding aims and objectives of the service, what care the patient can expect to receive, other services the patient may wish to access, discharge processes and how to complain
- carers, relatives and friends should have the choice to be involved with the patient care pathway and rehabilitation.
- all patients receiving palliative or end of life care from the NCT are given the opportunity to make an Advance Statement of Preferences and Wishes, have their preferred priorities of care recorded and that, for those on the end of life pathway, the Integrated Care Pathway is used

6.2 The Provider will ensure that the service actively encourages communication and engagement between themselves and key stakeholders. This communication should include the following as a minimum:
- patient surveys/questionnaires
- carer surveys/questionnaires
Key stakeholders will include but are not limited to:
- Patients and carers
- NCT staff, including the extended team
- GPs and Primary Care Teams
- Acute services staff
- Commissioning Teams
- Local Authority staff

### 7. Quality and Performance Standards

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<tr>
<th>Quality Indicator</th>
<th>Quality Performance Indicator</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Consequence of breach</th>
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<tbody>
<tr>
<td><strong>Infection Control</strong></td>
<td>All Staff with clinical roles to have received infection control training in the last 2 years</td>
<td>100% attainment Frequency of Reporting = Annually</td>
<td>% of Staff attendance Figures</td>
<td>&lt;100% attainment and/or Withheld reports will instigate Commissioner review. Providers may lose accreditation.</td>
</tr>
<tr>
<td></td>
<td>All Staff with Non clinical roles to have received infection control training in the last 2 years</td>
<td>90% attainment Frequency of Reporting = Annually</td>
<td>% of Staff attendance figures- annually</td>
<td>&lt;90% attainment and/or Withheld reports will instigate Commissioner review. Providers may lose accreditation.</td>
</tr>
<tr>
<td>Biannual infection Control Audit undertaken.</td>
<td>Frequency of Audit Reporting = Bi Annually, with at least one Control Audit undertaken in each 6 month period, and with no 2 Control Audits undertaken less</td>
<td></td>
<td>Infection control Audit report and action plan to be submitted</td>
<td>Withheld reports and/or action plans will instigate Commissioner review. Providers may lose accreditation.</td>
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<tr>
<td>Service User Experience</td>
<td>Inclusion of patient prospectus (including information prescription) as part of individual care plan.</td>
<td>Target: 100% of individuals have a personalised care plan including a patient prospectus</td>
<td>Data capture to evidence patient prospectus is part of an individual’s care plan. Annual audit for use of patient prescription</td>
<td>Withheld reports and/or action plans will instigate Commissioner review.</td>
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<td>Increased number of patients with a long term condition offered a place on a self care training programme such as the Expert Patient Programme and agree to attend. (CQUIN)</td>
<td>Target: 100% of patients offered a place on self care programme and this is recorded. Target: 70% of patients offered</td>
<td>Number of patients: o offered place on self-care programme (total and as % of all patients on NCT pathway with LTC) o accept place on self-care</td>
<td>Withheld reports and/or action plans will instigate Commissioner review.</td>
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Reduction in the incidence of urinary tract infections (UTI) in line with High Impact Actions for Nursing and Midwifery, Essential Steps Management of Urinary Catheter Care and preventing the spread of infection and Saving Lives clean safe care high impact intervention no 6 urinary catheter care bundle.

Development plan in place detailing how the NCT is planning to reduce the incidence of UTIs as per High Impact Actions for Nursing and Midwifery and in line with Essential Steps Management of Urinary Catheter Care and preventing the spread of infection, including Saving Lives clean safe care high impact intervention no 6 urinary catheter care bundle.

Number of patients on NCT pathway who are receiving catheter care and have a UTI.

Number of patients on NCT pathway who are receiving catheter care and have a UTI as % of total number of patients on NCT pathway who are receiving catheter care.

Number of patients on NCT pathway who are receiving pathway who are receiving catheter care.

Number of patients on NCT pathway who are receiving catheter care.

Number of patients on NCT pathway who are receiving catheter care.

Number of patients on NCT pathway who are receiving catheter care.
### Improving Service Users & Carers Experience

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<thead>
<tr>
<th><strong>Increased patient satisfaction</strong></th>
<th><strong>Target:</strong> 35% return each of user and carer satisfaction surveys.</th>
<th><strong>Measured through:</strong> Annual Patient satisfaction survey and Carer satisfaction survey.</th>
<th><strong>Withheld reports and/or action plans will instigate Commissioner review.</strong></th>
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<tr>
<td><strong>Increased carer satisfaction in relation to carer support.</strong></td>
<td><strong>Target:</strong> 90% record satisfied.</td>
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<td></td>
</tr>
<tr>
<td><strong>Increased carer support, linked to LA Carers strategy:</strong> (CQUIN)</td>
<td><strong>Target:</strong> 100% of carers offered a place on or signposted to a support programme and this is recorded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Target:</strong> 70% of carers offered accept a place on a support programme.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of carers:
- Identified
- Offered place on or signposted to a support programme (total and as % of all carers)
- Accept place on self-care programme

Patients and carers record ‘satisfied’ rating on survey forms returned.
| Unplanned admissions | Reduced number of individuals going into crisis and requiring emergency care, including preventing patient illnesses from deteriorating to the point where they need admission to hospital | Target: 10% reduction in acute non-elective activity | 1. Reduced acute activity:  
   - Non-elective Admissions  
   - A&E attendances (10/11 – benchmarking year)  
   - Re-admission after 10 days  
   - Analysis of frequent flyer data | <5% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation |
<table>
<thead>
<tr>
<th>Reducing Inequalities</th>
<th>Increasing access to an equitable NCT service for the whole ER population</th>
<th>Target: SPA available for each locality and linked to OOH services out of NCT operational hours</th>
<th>Audit of referrals through SPA to NCT, by patient group.</th>
<th>Evidence of EIA action plan outcomes. (Audits end Q1 and Q3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adherence to a policy of Equality and Diversity.</td>
<td>Evidence of Equality Impact Assessment and action plan implementation for each locality NCT.</td>
<td>Non-attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Reducing Barriers | Improved integrated working between health and other agencies including but not limited to social care, housing, the Police and voluntary organisations | Target: 95% of individuals whose care requires involvement of other agencies have a care plan reflecting this | Audit of patient care plans evidences support of other appropriate agencies if required is identified in the care plan Report end Q1 and end Q3. | &lt;90% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation |</p>
<table>
<thead>
<tr>
<th>Improving Productivity</th>
<th>Increase in number of NCT contacts:</th>
<th>Speed of response to referral against criteria.</th>
<th>Target: 10% increase in face to face and 15% non face to face from baseline (see section 8, numbers 2 &amp; 3)</th>
<th>Number of face to face contacts Number of non face to face contacts</th>
<th>Performance report (see section 8)</th>
<th>&lt;5% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Response time between patient being contacted and reviewed by telephone after a referral is received. Appropriateness of urgency is assessed and unnecessary waits for inappropriate referrals reduced. The</td>
<td>Target: 100%</td>
<td>Urgent referrals are telephoned, clinically triaged and prevent admission visit takes place within 4 hours. Routine referrals are telephoned and clinically triaged within 1 working</td>
<td>&lt;90% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>most appropriate clinician assesses the patient.</td>
<td>Target: 100% Target: 100% (Phased implementation of locality SPAs, as agreed with commissioners, but all in place by end Q1)</td>
<td>days. Target: 100% referrals responded to within target response time. Evidence of 100% NCT referrals through SPA for each locality Evidence 100% referrals responded to within target timescales</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Point of Access available for each locality NCT.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
<td>Effective clinical outcome achieved and demonstrated through Patient Reported Outcome Measure (PROM) process. (As per PROM measurement agreed with commissioners.) (CQUIN)</td>
<td>Target: 85%</td>
<td>PROM agreed for a key area of LTC service delivery. 85% patients report through PROM process achievement of effective clinical outcome. &lt;80% attainment and/or Withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients receiving palliative care or on end of life pathway have completed management plan</td>
<td>Target: 100%</td>
<td>Management plan completed on SystmOne for all patients receiving palliative care or on end of life pathway. Undertake audit.</td>
<td>&lt;90% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients expected to die within 6 months (ie, on end of life pathway) have preferred place of death recorded and met.</td>
<td>Target: 100%</td>
<td>% patients on NCT pathway and EOL pathway who express a preference to die at home have their preference achieved</td>
<td>&lt;90% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Additional Measures for Block Contracts:

By 1st April 2010 all preliminary Discharge Summaries/results to be electronic, high quality and received by the referring clinician within 24 hours.

- **100% attainment.**
- Completed Delivery-Plan and implementation
- Frequency of progress reporting = Monthly

**Delivery and Implementation Plan.**

- Monthly Progress reports.
- Annual audit of summaries.

Absence of Delivery Plan and/or Withheld Progress reports will instigate Commissioner review and Providers may lose accreditation. Poor progress will instigate Commissioner review and – Providers will lose accreditation.

### Staff turnover / sickness levels

**HR Measures:**
- Providers to monitor and record the following.
  - Staff Absence
  - Staff Turnover

**Target for Staff Absence** is ≤ 5%

**Target for Staff Turnover** ≤ 10%

**Frequency of Reporting** = Quarterly two months after month end.

**Provider summary report of % of Staff Absences and Turnover.** Report template as provided

Commissioner will request Provider Recovery Plan. Withheld reports and/or Recovery Plan will investigate Commissioner review. Providers may lose accreditation.

### Sickness levels

- **Agency and bank spend**

- **Contacts per FTE**

### 7a. Outcomes
<table>
<thead>
<tr>
<th><strong>Outcome Indicator</strong></th>
<th><strong>Outcome Performance Indicator</strong></th>
<th><strong>Threshold</strong></th>
<th><strong>Method of measurement</strong></th>
<th><strong>Consequence of breach</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved quality of life for patients</td>
<td>Improved quality of life demonstrated through Patient Reported Outcome Measures (PROMS) process. (As per PROM measurement agreed with commissioners.)</td>
<td>Target: 85%</td>
<td>PROM agreed for one key area to evidence improved quality of life reported by patients. 85% patients report through PROM process improved quality of life. (Score minimum of 3 on PROM scale)</td>
<td>&lt;90% attainment and/or Withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
</tr>
<tr>
<td>Effective discharge process for patients, to facilitate timely and appropriate discharge from community beds</td>
<td>Reduced length of stay and delayed discharge</td>
<td>Target : 10% reduction in delayed discharges</td>
<td>Provider prevent admissions data and community bed activity data evidencing reduction in:  - delayed discharges  - LOS</td>
<td>&lt;5% attainment and/or withheld reports will instigate Commissioner review. Providers may lose accreditation</td>
</tr>
<tr>
<td>Reduced length of stay in community beds</td>
<td>Increase in facilitated discharge</td>
<td>Target: 10% reduction in LOS</td>
<td>Trend analysis of community activity data Identified baseline</td>
<td></td>
</tr>
<tr>
<td>Quality assurance for NCT service in place</td>
<td>Prioritised annual Clinical Audit programme agreed with Commissioner</td>
<td>5 audit areas agreed to include at least one area in relation to auditing the implementation of a specific NICE guideline relevant to NCT (to be agreed by 31.3.10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The service meets all national standards of service quality and clinical governance requirements, including compliance with:</td>
<td></td>
<td>Agreed audits to include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- standards set out standards set out by the CQC</td>
<td></td>
<td>- Number of inappropriate referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NICE guidance and updates</td>
<td></td>
<td>- MDT meetings as part of proactive case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achievement of quality outcomes specified in sections 7 &amp; 7a. and additional outcomes specified for NCT service elements (see sub-specifications).</td>
<td></td>
<td>As 7. and 7a performance measures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance reporting as identified (7 &amp; 7a)</td>
<td></td>
<td>Audits indicate significant assurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>of discharges delayed by lack of community services support.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 8. Activity

<table>
<thead>
<tr>
<th>Activity Performance Indicators</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Consequence of breach</th>
<th>Report Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard data set defined below, to be collected for each</td>
<td>Data to be submitted via provider</td>
<td></td>
<td>Performance report to be submitted</td>
<td></td>
</tr>
<tr>
<td>member of the NCT, in addition to agreed qualitative data specified in sections 7. and 7a.</td>
<td>performance report (see Appendix 4). Report to include data for all indicators described below and qualitative indicators specified in sections 7. and 7a.</td>
<td>quarterly by the Provider.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1. Total referrals, by source of referral:  
  - Primary Care  
  - Community  
  - Acute Trust  
  - Ambulance Service  
  - Mental Health  
  - Falls service  
  - Other | Target: 10% increase for all referrers | <10% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties. |
<p>| 2. Number of first face to face contacts by service | Target: 10% increase | &lt;10% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties. |
| 3. Number of follow up face to face contacts by service | Target: 10% reduction | &lt;10% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties. |
| 4. Number of face to face contacts for patients identified proactively at increased risk of readmission | Target: 10% increase | &lt;10% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties. |</p>
<table>
<thead>
<tr>
<th>5. Number of non-face to face (telephone) contacts (Telephone contact is call of more than 10 minutes duration or involves significant clinical input and outcome eg, prevent admission)</th>
<th>Target: 15% increase</th>
<th>&lt; 15% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Service cancelled appointments</td>
<td>Target: 10% reduction</td>
<td>&lt; 10% reduction and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</td>
</tr>
<tr>
<td>7. Failed visits (ie, DNA in patient’s home)</td>
<td>Target: 10% reduction</td>
<td>&lt; 10% reduction and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</td>
</tr>
<tr>
<td>7. DNAs</td>
<td>Target: 5% reduction</td>
<td>&lt; 5% reduction and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| 9. Waiting time from receipt of referral to first face to face contact | Target: 100% referrals responded to within target  
Targets: Urgent referrals are telephoned, clinically triaged and prevent admission visit takes place within 4 hours.  
Routine referrals are telephoned and clinically triaged within 1 working days. | < 95% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties. |   |
| 10. Average caseload per team member by role:  
- Community Matrons  
- NCT nursing Team (excluding Community Matrons)  
- Physiotherapists  
- Occupational Therapists | Target: equity of caseload across all NCTs in relation to weighted population |   |   |
<p>| 11. Number of patients referred to an acute hospital within 10 days following a NCT | Target: 10% reduction | &lt; 10% reduction and/or withheld reports will instigate |   |</p>
<table>
<thead>
<tr>
<th>intervention</th>
<th>Target: 5% increase</th>
<th>&lt; 5% increase and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Number of patients referred to a community hospital</td>
<td>Target: 90%</td>
<td>&lt; 85% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</td>
</tr>
<tr>
<td>13. Number of patients on End of Life pathway and NCT pathway who express a preference to die at home have the preference achieved</td>
<td>Target: 90%</td>
<td>&lt; 85% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</td>
</tr>
<tr>
<td>14. Number of patients on End of Life pathway and NCT pathway who express a preference to die in a community hospital have the preference achieved</td>
<td>Reduction in number of patients who die in acute setting where it is not their preferred place of death</td>
<td>No reduction attained and/or withheld reports will instigate Commissioner review. Providers may incur penalties.</td>
</tr>
<tr>
<td>15. Number of patients on End of Life pathway and NCT pathway who express a preference to die either at home or in a community hospital die in an acute setting</td>
<td>Target: 10% reduction</td>
<td>&lt;10% attainment and/or withheld reports will</td>
</tr>
</tbody>
</table>
17. Number of prevented admissions and breakdown by reason for referral

**Target:** 20% increase

<20% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties.

18. Number of falls patients referred to NCT and diverted from A&E attendance

**Target:** 10% increase

<10% attainment and/or withheld reports will instigate Commissioner review. Providers may incur penalties.

---

**Activity Plan**

The Provider will ensure that activity data is provided to meet the agreed performance monitoring requirements.

The provider will submit activity and performance information both as a total for the NCT and broken down by individual functions within the NCT, as required and in line with that detailed in the NCT service specification (including the submission of a locally agreed Contract Dataset).

**9. Continual Service Improvement Plan**

Future performance targets and thresholds to be agreed with commissioners, following establishment of baseline targets.

**10. Prices & Costs**

**10.1 Price**

<table>
<thead>
<tr>
<th>Basis of Contract</th>
<th>Unit of Measurement</th>
<th>Price</th>
<th>Thresholds</th>
<th>Expected Annual Contract Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block/cost &amp; volume/cost per case/Other________*</td>
<td>£</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>£</td>
<td>£</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*delete as appropriate*
Appendix 1 - Integrated Unscheduled Care Model: Summary
Appendix 2

2.1 SUB-SPECIFICATION – NURSING SERVICE

Service Description:

This sub-specification should be read and construed in conjunction with the Key Performance Indicators and other requirements and standards set out in the NCT service specification. The NCT nursing service delivers flexible, integrated, holistic and patient centred care, to patients who have a nursing need and their carers.

A full range of community nursing services is commissioned within the NCT service specification. This includes Community Matron, District and Community Nursing Teams, who will deliver the urgent care (rapid response), intermediate care and long term conditions management described in the core NCT specification (see sections 3.1 and 3.2). The NCT nursing service will have input from and direct access to specialist nursing services (as described in section 2.1).

Care is delivered by a team of appropriately skilled and qualified registered nurses supported by health care assistants and associate practitioners. The following core interventions will be delivered by the NCT nursing service:

1. Holistic assessment, including:
   - identification of carer and onward referral for those who would benefit from carers assessment or signposting to other services
   - advice/health education to patients and unpaid carers including accident prevention

2. Diabetic Medication by injection (no oral medication).

3. Medicine Administration by injection

4. Chronic Wound care, including stoma care and acute wound care.
   Wound clinic service as per separate service specification.

5. Chronic leg ulcer management

6. Blood tests: the NCT nursing service will carry out blood tests to housebound patients. Any query by the nursing service regarding a blood requested for a housebound patient will be dealt directly with the referring GP practice.
   Bloods will be taken for one collection only per day.

7. Non-urgent nursing management of patients with chronic conditions

8. Support for individuals with palliative and/or end of life care needs

9. Early support for the individual with terminal cancer diagnosis
10. Requests for assessment for equipment where there is an urgent need within 24hrs, e.g. palliative care

11. Specialist nursing care/interventions/treatments, e.g. enteral feeding, syringe drivers

12. Patients requiring urgent clinical intervention, e.g. catheter & bowel care


14. Level 2 falls assessments

15. Continence promotion and management of incontinence

16. Discharge planning from NCT caseload

17. Provision of teaching and ongoing support to individuals and their carers to enable them to self care

The use of personalised care plans, End of Life tools (including the Advance Care Plan and Integrated Care Pathway) and participation in MDT meetings as part of proactive case management by all NCT nursing staff, as appropriate, is expected and will be performance monitored. Clinical inputting of data onto SystmOne modules will be completed by all NCT nursing staff, including the End of Life management template.

**Scope of the Service:**

The locality NCT nursing service is commissioned to deliver services to the patient in the most appropriate setting. This may be in the patient’s home if the patient is housebound*. However, if the patient is ambulant upon entry to the service or becomes ambulant during treatment, care may be provided in a community setting if appropriate (e.g., clinic in a Primary Care premises). As the patient’s condition improves, they may be required to visit a practice nurse or a specialist clinic run by the NCT nursing team.

(*A housebound patient is defined as a patient to whom the practice normally offers home visits as this is the only practical means of enabling the patient a face to face consultation with a general practitioner.)

The provision of leg ulcer and continence clinics will be determined at locality level (In certain localities, leg ulcer or continence services have historically been provided). Discussions between the Provider and GP practices will determine whether to maintain the status quo, redesign existing services or commission through additional (PbC) investment.

The nursing service is not commissioned to routinely support the Quality and Outcomes Framework in Primary Care, but is commissioned to provide care that is integrated with Primary Care services and is in the best interests of patients, ensuring the number of visits is kept to a minimum and the health outcomes maximised.

The NCT nursing service will provide ongoing access for people with long-term conditions living at home to a comprehensive range of nursing care, advice and support, to meet their continuing
and changing needs, to increase their independence and autonomy and help them to live as 
they wish. This will form part of a range of therapeutic health and social care services within the 
integrated NCT, ensuring seamless transition to supported long-term care is achieved.

**Objectives:**

- To shape service provision around the needs of the people of the East Riding with 
  patients at the centre of care.
- Reduce health inequalities by meeting local needs
- Support patients in a community setting with a range of care needs to minimise acute 
  hospital admissions
- Facilitate hospital discharge where appropriate in line with the relevant care pathway in 
  order to reduce emergency bed days and length of stay
- Maintain patients at the end of their lives or in a crisis at home, if that is the patient’s 
  choice, in order to reduce deaths in an acute setting
- Provide education, pro-active self-management and ongoing care of patients with long 
  term/chronic conditions

**Delivery and Performance**

The service will be expected to contribute to the delivery of and be measured against the 
Performance indicators and standards as set out in the NCT service specification.

Performance reports will be submitted by the Provider as agreed within the performance 
monitoring framework.

**Performance Indicators**

Performance of the NCT nursing service will be undertaken through monitoring of the 
performance measures and metrics outlined in sections 7, 7a and 8 of the core NCT service 
specification.

---

**2.2 SUB-SPECIFICATION – REHABILITATION SERVICE**

**Service Description:**

This sub-specification should be read and construed in conjunction with the Key Performance 
Indicators and other requirements and standards set out in the NCT service specification.

Provision of a comprehensive range of rehabilitation, advice and support, to meet continuing and 
changing needs, to increase independence and autonomy, enabling patients to live as they 
wish.

The Rehabilitation service is delivered primarily through Occupational Therapists, 
Physiotherapists and Rehabilitation assistants.

The service also provides supported discharge to enable rehabilitation to continue at home (or 
rehabilitation beds) thus allowing earlier discharge from acute care.
The NCT rehabilitation service will provide ongoing access for people with long-term conditions living at home to a comprehensive range of rehabilitation, advice and support, to meet their continuing and changing needs, to increase their independence and autonomy and help them to live as they wish. This will form part of a range of therapeutic health and social care services within the integrated NCT, ensuring seamless transition to supported long-term care is achieved.

**Scope of the Service:**
The key elements of the service are:
- Assessment by any combination of the following - social worker, physiotherapist, occupational therapist, nurse. This will identify key risks and needs to be fully agreed with the person receiving the service.
- Care plan defining social care and rehabilitation goals
- Access to intermediate care beds to allow further assessment & rehabilitation in a more secure environment, if required
- Up to 6 weeks rehabilitation in a person’s home setting
- Equipment and adaptations to promote safety & independence
- Planned onward referral to other agencies/services where appropriate

The Rehabilitation service will work collaboratively with the NCT nursing service to offer integrated nursing and rehabilitation care, ensuring a seamless service to patients.

**Objectives:**
- To provide a needs led, patient centred and evidence based rehabilitation programme to those people referred to the NCT service
- To provide specialist information and education regarding conditions and their effects to patients and carers to enable the patient to self manage
- To improve the individual’s ability to participate in valued activities
- To prevent or reduce the incidence of acute hospital admission for those patients who can effectively be maintained within their own home through the provision of a rehabilitation programme
- To reduce the number of appointments made and visits to the GP Surgery
- To provide specialist information/advice to other professionals.
- To facilitate early discharge

**Delivery and Performance**
The service will be expected to contribute to the delivery of and be measured against the Performance indicators and standards as set out in the NCT service specification.

Performance reports will be submitted by the Provider as agreed within the performance monitoring framework.

**Performance Indicators**
Performance of the NCT rehabilitation service will be undertaken through monitoring of the performance measures and metrics outlined in sections 7, 7a and 8 of the core NCT service
Specific additional indicators for Physiotherapy:

- Reduction in community packages as a result of rehabilitation
- Reduction in readmission as a result of Community Rehabilitation
- Evidence of improved quality of life measures (PROMs)
- Community Provision (seen) - % of Face to Face Community Activity not converting to secondary care referrals
- Community Provision (Telephone) if applicable - % of ‘Telephone Advice’ Community Activity not converting to secondary care referrals

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**Appendix 3**

*(SCHEDULE OF CONTRACT PERFORMANCE INDICATORS – NCT SCORECARD)*

Produced as separate Excel spreadsheet.