SCHEDULE 2 – THE SERVICES

A. Service Specification

Service specification number	
Service Commissioner Lead	**Tammy Lott/Rebecca Johnson**
Provider Lead	**Claire Underwood/Alison Shortman**
Period	**April 2013 – March 2014**
Date of Review	**March 2014**

1. Population Needs

1.1 National Context and Evidence Base

Falls are a major cause of disability and the leading cause of mortality due to injury among older people aged over 75 in the UK. Nearly a fifth of older people who break their hips die, and of those that survive, less than one third regain their same level of mobility. Hip fractures cost UK society an estimated £726 million per annum, of which half is attributed to social care.

Falls on the stairs alone account for an estimated 1000 deaths of older people each year and a further 330,000 serious injuries. Falls are considered a major factor leading to premature admission to permanent residential care. The after effects of even the most minor fall can be catastrophic for an older person's physical and mental health. The UK population is ageing and therefore the cost of falls incurred by the NHS and other agencies is expected to escalate. Based on current trends, hip fractures among older people resulting from a fall may rise to 120,000 per annum by 2015.

There is an abundance of research into falls in the elderly population, stating that falls are a leading cause of death from injury in people over the age of 75 years, and that people over the age of 65 years suffer from at least one fall a year. The impact on the NHS in the hospitalisation and treatment of injuries associated with falls injuries is phenomenal.

People over the age of 65 years old account for 66% of all hospital admissions, and 40% of all emergency admissions.

To improve disease management and reduce avoidable falls related hospital admissions, there is a need for an effective community based falls service, to support the most appropriate management of patients in the most appropriate setting.

Factors Known to Contribute to the Risk of Falls in Elderly People

Intrinsic:

- Ageing process (risk increases over 65 years)
- Poor mobility
- Cognitive impairment /confusion/agitation
- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status

- Emotional distress/depression

Extrinsic:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise
- Environmental hazards (steps, stairs, worn carpets, rugs etc.)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing/cooking etc.)

Evidence Base

- Our Health, Our Care, Our Say: A New Direction for Community Services, DoH 2006
- Department of Health (2001) The National Service Framework for Older People, Department of Health, London
- NHS Plan (2006)
- Earlier, risk managed discharge plan = reduction in "bed blocking" days (Ward 2007, RCP 2005)
- Choosing Health, DoH 2004
- The Operating Framework for the NHS in England [2012/13] (or any updated version thereof)
- Shifting Care Closer to Home Policy DoH 2008
- High Quality Care for All DoH 2009
- Codes of Professional Conduct – General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)
- The Cochrane Review - Interventions for preventing falls in elderly people 2009
- The assessment and prevention of falls in older people – NICE 2004, CG21

Compliance with CQC Essential Standards of Quality and Safety and appropriately registered with the CQC to demonstrate this.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing peoples 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 harm**

2.2 Local Defined Outcomes

- High patient and referrer satisfaction
- Reduction in acute admissions for falls related problems

- An evidence based, structured falls education programme
- An evidenced based health promotion toolkit
- A falls winter plan
- Attendance at weekly MDT virtual ward meetings
- Improved access and choice in a community setting
- Improve education regarding the intrinsic and extrinsic contributors to falls
- Improve patient self management
- Provision of electronic patient records
- Provision of patient and carer education
- Improved clinical outcomes for patients
- Compliance with Local Quality Indicators
- Development and implementation of a bi- annual clinical audit, based on local and national priorities. This shall include an audit of 10% of cases, to ensure that they are managed in line with best clinical practice.
- Provide comprehensive data submission on a quarterly basis
- Provide prompt response to adhoc data requests
- Agree clinical outcomes to be expected from interventions

The delivery of the standards and outcomes described in this specification is the requirement to deliver a maximum 18-week referral to treatment patient pathway.

3. Scope

3.1 Aims and objectives of the service

To commission evidence based, patient centred, high quality, value for money service for the prompt rehabilitation and treatment of patients who have fallen or are at risk of falling within a community setting.

Objectives

- Ensure high quality of care, by ensuring patients are treated in accordance with all relevant National guidance and that patient outcome data is collected and monitored (including patient reported outcomes as these are developed).
- Ensure sound clinical governance of services and continuing service improvement/innovation.
- Ensure patients are fully informed of their condition and treatment, and that they are provided with an appropriate format of information.
- Ensure compliance with national waiting time targets and other key national and local quality and performance targets.

3.2 Service description/care pathway

The Falls Service is a community based service for the assessment and rehabilitation of patients at risk of or who have suffered a fall.

The Service shall be accessible Monday to Saturday, 8.00 am – 8.00 pm, 52 weeks per year excluding bank holidays via a single point of access.

The Service hours, function and processes of the unit(s) shall be sufficiently flexible to accommodate

future changes in service volume and to ensure that patients have timely access to the service, available outside normal 9-5 hours Monday – Friday.

The Provider shall establish, maintain and proactively engage with patients and groups to ensure the timings and availability of the Services meets patients' needs. The Provider shall engage with these groups on at least a quarterly basis and demonstrate to Commissioners what action is being taken to address the concerns, or issues, raised by patients.

Appropriate treatment and diagnostics, including reviewing cardiac and neurological systems, shall be provided as required. This may require onward referral to the most appropriate health professional.

The Provider shall provide the service within the community to ensure care is delivered close to the patient's home. 25% of patients shall receive a domiciliary falls programme, however it is anticipated that this percentage may shift depending on the patient and local population needs to ensure the most effective use of resources.

The Provider shall offer each patient a choice of locations for their appointments.

The service shall deliver

- Patient choice of appointment
- Flexible appointments to support more urgent demand or unplanned care (response times)
- Relevant and timely signposting
- Face to face standard assessment with relevant investigations
- Mutually agreed and appropriate management to include individualised care bundles (treatment) and treatment plans for all patients
- Promotion and support the development of self care
- Patient information leaflets and lifestyle support
- Appropriate follow up to include review
- Communication as necessary to the patient's own GP referring clinician and after first consultation, and when adjustments are made to treatment and on discharge
- Relevant initial training and education in continence treatment to equip other healthcare workers across primary care and secondary care to access services on behalf of and for the benefit of patients
- An integrated service which can positively contribute to the local health care community and social care

Commissioners, in partnership with Primary care colleagues have considered evidenced based practice and have produced a pathway for patients at risk of or who have fallen. Providers are expected to deliver the Falls Service in line with the Care Pathway **Appendix One**. The Falls Service shall interface seamlessly with referring GPs and secondary care to ensure direct and unencumbered patient pathways.

The Provider shall deliver the following generic model

- Telephone/e-mail advice service available for GP/Primary Care queries
- Choice of day and time of appointment made by patient (or carer) with at least 2 weeks notice for non urgent patients.
- Referral clinically assessed against eligibility criteria and accepted

- Patient referred back to the referrer, if referral criteria are not met or are against commissioning policies.
- Provider to enable access to diagnostics (e.g. DEXA scans) including reviewing cardiac and neurological systems which may require onward referral to the most appropriate health professional.
- Treatment options; falls education programme, including medication review, foot care and full falls screening assessment. Treatment to be provided in line with agreed clinical protocols and NICE guidelines (where applicable) and best practice guidelines
- All referrals, to be triaged within 24 hours of referral being received.
- Telephone advice for patients

3.3 Accessibility

Service User Transport

The Provider must adhere to all Cannock Chase and Stafford & Surrounds Service Users Access Principles.

Service Users requiring transport will be subject to Service Users Transport Guidelines and will be required to meet the Service Users eligibility criteria. It is the Provider's responsibility to only offer and book transport where a Service Users is unable to get to the clinic setting themselves. The responsibility for funding the cost of Service Users transport is that of Cannock Chase and Stafford & Surrounds Clinical Commissioning Groups.

The Provider will provide information about any reimbursements made to Service Users, in line with the Hospital Travel Cost Scheme (NSL Care Services working in South Staffordshire, 0333 240 0265) and recharge the Clinical Commissioning Groups accordingly.

The Provider will ensure that information provided to patients is available in suitable formats for patients with low vision.

3.4 Population covered

This service specification covers adults over the age of 65, resident in the geographical area of Cannock Chase and Stafford & Surrounds Clinical Commissioning Consortia. The Falls Service shall only accept referrals from patients registered with a GP within Cannock Chase and Stafford & Surrounds and meet the referral criteria. This shall also include the transient population.

3.5 Any acceptance and exclusion criteria

The Provider shall ensure that all referrals are reviewed by appropriately skilled clinical staff to enable compliance with the Provider's obligations set out in this Service Specification.

Cannock Chase and Stafford & Surrounds Clinical Commissioning Consortia have commissioned this service and it is anticipated that referrals will only come from patients registered with a GP within these areas. Any referrals received outside these geographical areas will be rejected.

The Provider shall accept referrals received by post, fax or by secure electronic transmission.
The Provider must ensure that appropriate arrangements and systems are in place to provide a robust directly bookable Choose and Book process.

3.6 Exclusion Criteria

- Any adult under 65 years of age (NICE guidance >65 risk of falls)
- Any adults who score less than 2 on the falls screening tool
- Acute episode/exacerbation of illness that requires an acute hospital environment to deliver care needs
- Acute injury/trauma that requires an acute hospital environment to deliver care needs
- Nursing Home patients
- Amputees – to be referred onto the Amputee Clinic, MSFT
- Advanced Dementia patients; for patients scoring 10 or below on the Mini State Mental Examination (MMSE)
- Palliative patients
- Wheelchair bound
- Acute episode of self-harm
- Adults who are under the influence of alcohol/substance misuse
- Patients with a permanent impairment of the functioning of the brain as a result of a brain injury and are unable to live independently.
- Learning disability patients; those not living independently.

3.7 Response time and prioritisation

All patients shall be seen as follows:

Critical and urgent patients – verbal contact made within 24 hours and assessment date offered Non-urgent – substantive/routine – verbal contact to be made within 5 days and an appointment offered within 14 days from the date of referral. The circumstances surrounding any patient not being seen within this time period shall be reported to the Commissioner by the Provider.

The Provider shall ensure that:

1. All patients fulfilling the referral criteria referred to the Service are contacted, within 5 Operational Days of the Provider's receipt of the referral, in order to agree an appropriate time and date of appointment. For critical and urgent patients – triaged within 24 hours of referral, verbal contact shall be made on the same day as receipt of the referral. The Provider shall ensure that all patients are offered a selection of at least 3 different initial appointments and shall use its best endeavours to arrange the patient's initial appointment within 14 Operational Days of the Provider's receipt of the referral. The agreed appointment will be confirmed to the patient verbally or writing by the Provider.
2. Referrals are not rejected on the basis that the Provider has not been able to arrange an appointment with a patient in accordance with this Service Specification.
3. An appropriately qualified and competent member of the Provider's staff reviews all referrals upon receipt to ensure the appointments are offered to patients in accordance with this Service Specification and in a manner that takes account of clinical urgency and necessity.
4. Where it is deemed necessary to notify patients of their appointment then the patient shall be contacted two days prior to their appointment time, to remind the patient of this appointment. This shall be at the Providers discretion, unless the Commissioner becomes aware of increased DNAs.

3.7.1 Referrals

The service shall ensure that patients are able to access services in a timely manner.

1. The Provider shall accept referrals from varying sources to include GP's, District Nurses, Community Matrons, Practice Nurses, Opticians, Secondary Care, A&E, Ambulance Service, Voluntary sector and Social Care.
   Self referral for review/reassessment if the patient is discharged at 6 months with open access up to 12 months post discharge.
2. Referral arrangements operated by the Provider shall be simple, streamlined and promote speedy access to services.
3. The Provider shall ensure that it markets the Service and that it provides comprehensive information about the Service it provides, including, without limitation, the referral mechanism. This information shall be sent to GPs and other potential Referrers. The Provider shall ensure that the information is up to date and circulated regularly.
4. The Provider shall accept referrals via the single point of access.
5. The Provider shall work collaboratively with the Commissioner and Referrers to improve the quality and standard of referrals to minimise inappropriate referrals and optimise the information received in referral documentation.
6. The Provider shall clinically assess the referral against the agreed criteria and refer the patient back to the referrer, if the criteria are not met. If the referral form is not complete, the provider must contact the referrer to obtain the information required.
7. Rejected referrals: The referrer shall be telephoned to advise of the reason for rejection for those referrals received from West Midlands Ambulance Service and A&E staff. The conversation shall be documented in the patients notes and Lorenzo.

3.7.2 Assessment & Diagnosis

The service shall provide a clinically appropriate assessment of the patient using a recognised Falls Screening Tool for example; the Falls Risk Assessment Tool and shall adhere to NICE Guidelines CG21.

1. Critical and urgent referrals are verbally responded to on the same day (or next working day) and assessment date offered.
2. Non urgent referrals are verbally responded to within 5 days of receipt of referral and appointment offered within 14 days from receipt of referral.
   - All patients meeting the referral criteria shall be offered an initial assessment (MDT /GP review where appropriate) within 2 weeks of the date of referral supported by any tests required to assist diagnosis/assessment.
   - Following assessment, the patient shall then follow the Community Falls pathway. Self care is promoted wherever clinically appropriate.

3.7.3 Treatment

The service shall ensure that treatments achieve the best outcomes for the patient.
Following the assessment, the Provider shall develop a Care plan for each patient and shall ensure that:

1. Informed consent to examinations and/or treatment is obtained from all patients.
2. The service environment meets the standards laid down by all National Guidance

3. The treatment is carried out in accordance with the relevant National policy and guidance .
4. Patients who require specialist treatment are referred to appropriate providers in line with local Commissioning Policies.
5. Medication reviews are initiated by the Provider and where appropriate GP to continue with prescriptions, in accordance with the Commissioners Medicines Management requirements, as provided for in the Quality Requirements.
6. Patients/carers receive adequate information
7. Self care to be promoted wherever clinically appropriate
8. Patient education to be provided, as part of assessment and education programme

Upon establishing each patients need the Provider shall provide all necessary services to the patient in accordance with this Service Specification and in respect of any activity subsequently provided to a patient shall charge the Commissioner in accordance with this Agreement. Services are to be provided at the Provider Premises and within the patient's home where appropriate.

3.7.4 Follow up

Aftercare and follow up are crucial to ensuring that patients experience the best possible outcome. This specification aims to ensure that patients receive suitable aftercare and follow-up, delivered in an environment to meet their needs.

1 Patients shall be reviewed at 6 - 12 weeks – domiciliary visits and group work 12 weeks and upto 6 months where it is identified that the individual would benefit from continued domiciliary visits.
2 Telephone reviews shall be used where agreed with the Commissioner and/or patient.

3.7.5 Care Pathways

The care pathway shall include falls assessment, medication review, foot care, education programme (where appropriate) to include but not limited to

- Physiotherapy
- Podiatry
- Occupational Therapy
- Voluntary Agencies (Age UK)
- Optician
- Pharmacist
- Diagnostics (e.g. DEXA scans, including reviewing cardiac and neurological systems) as required

3.7.6 Transfer and discharge from care obligations

Patients shall remain with the service for a maximum of 6 months upon which time they shall be discharged with open access up to 12 months post discharge.

Onward referrals shall be made as appropriate e.g. Social Services, Community Matron, Wheelchair Service.

If the Service rejects a referral, then the referrer shall be contacted via telephone within 2 days to advise of the reason why, particularly A&E and Ambulance Crews and the conversation documented

in the patient's notes.

Written instructions and information should be given to the patient about what to do and who to contact in the event of problems or concern resulting from their treatment or care.

Arrangements for Planned Discharges

The Falls Service shall be involved with planned discharge from secondary care as requested.

On completion of treatment, the Provider shall communicate, by way of written letter/checklist review for patients, the outcome of the treatment including without limitation the outcome on all the above matters to the patient, the patient's GP and Referrer. This communication constitutes a Clinic Letter in the context of this Service Specification and shall be issued by the Provider within 2 Operational Day following the patient's discharge. The Provider shall issue letters by Royal Mail (First Class Postage) or via a secure internet based solution, such as NHS Net Mail or as may be directed by the Commissioner and agreed with each Referrer and patient. In addition to the above the Provider shall ensure that each Clinic Letter, where applicable, contains

- A diagnosis or working diagnosis
- a Care Plan, including all information that may be required by the Referrer and GP to provide ongoing care to patients.
- the correct patient's and GP's details. The letter should also plainly state what further action the patient's GP is being requested to undertake and the underpinning rationale, in particular where this relates to the initiation or continuation of medication prescribing.
- A problem header (to facilitate READ coding at GP surgeries) and record of medication.
- All changes in medication to be communicated legibly to the GP with a letter to the patient explaining that the onus is on them to request the medication (medication being restricted to those items joint formulary).
- Recommendations regarding the future management of a patient if appropriate.

Patients information/Self care

The Provider shall produce leaflets and signposting information for patients as required. This information shall be made readily available in GP practices, clinic locations and across the whole system organisations. Patients or carers can be provided with this written information if the Provider is contacted for information prior to the decision to refer. All written patient literature shall be current and up to date with appropriate copyright acknowledgements. Print materials shall be made available in large print and alternative languages to reflect the needs of patients and always if requested. Patients and/or carers must be provided with contact numbers for the Continence Service should they require any further information or advice pre or post discharge.

3.7.7 Interdependence with other services/providers

The Provider shall work in partnership with

- Local General Practitioners (GPs)
- Diagnostic Services
- Local Acute Trusts, including specialist centres
- Local NHS Community Service providers
- Independent and Third Sector Providers
- Pharmacists

- Opticians
- Commissioning PCTs
- Local Authority Social Services Departments
- Local third sector organisations

The success of the Service shall be dependent on strong working relationships with GPs and community based professionals e.g. Intermediate Care Team and Community Intervention Service. The Provider is expected to engage with referrers through marketing the service, holding a minimum of yearly education sessions and providing feedback to referrers when referrals are rejected together with clear management plans for patients when they are discharged back to the care of the GP.

3.7.8 Subcontractors

Any subcontractor arrangements must be approved by Cannock Chase and Stafford & Surrounds CCGs.

4 Applicable Service Standards

4.7 Applicable National Standards (e.g. NICE)

- NICE Guidance CG21, 2004 The assessment and prevention of falls in older people

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

Professional codes of conduct for staff e.g. The Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)

Sub-contractors

Any subcontractor arrangements must be approved by Commissioners.

5 Applicable quality requirements and CQUIN goals

5.7 Applicable quality requirements (see schedule 4 parts A-D)

5.8 Applicable CQUIN goals (See schedule 4 Part E)

6 Location of Provider Premises

The Provider premises are located at:

7 Individual Service User Placement

SECTION B PART 8 - QUALITY

Section B Part 8.1: Quality Requirements

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach
Service User experience Baseline	Initial questionnaire	>95%	Quarterly Management Report	Each breach shall be deemed by the Parties to constitute a failure by the Provider to achieve this Quality Requirement and Clause 32 of Module C shall apply
Assessment	Service User review within 6 months of initial assessment	>95%	Six month reports to include: - Audit on quality of completed initial assessments - Reduction in products used	Each breach shall be deemed by the Parties to constitute a failure by the Provider to achieve this Quality Requirement and Clause 32 of Module C shall apply
Improved Quality of Life Effectiveness of clinical outcomes	Service User reported Quality of Life Indicators pre and post treatment to demonstrate improvement/cure rate	>95%	Quarterly Management Report	Each breach shall be deemed by the Parties to constitute a failure by the Provider to achieve this Quality Requirement and Clause 32 of Module C shall apply
Service User experience	Post treatment questionnaire	>95%	Quarterly Management Report	Each breach shall be deemed by the Parties to constitute a failure by the Provider to achieve this Quality Requirement and Clause 32 of Module C shall apply
Activity				

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach

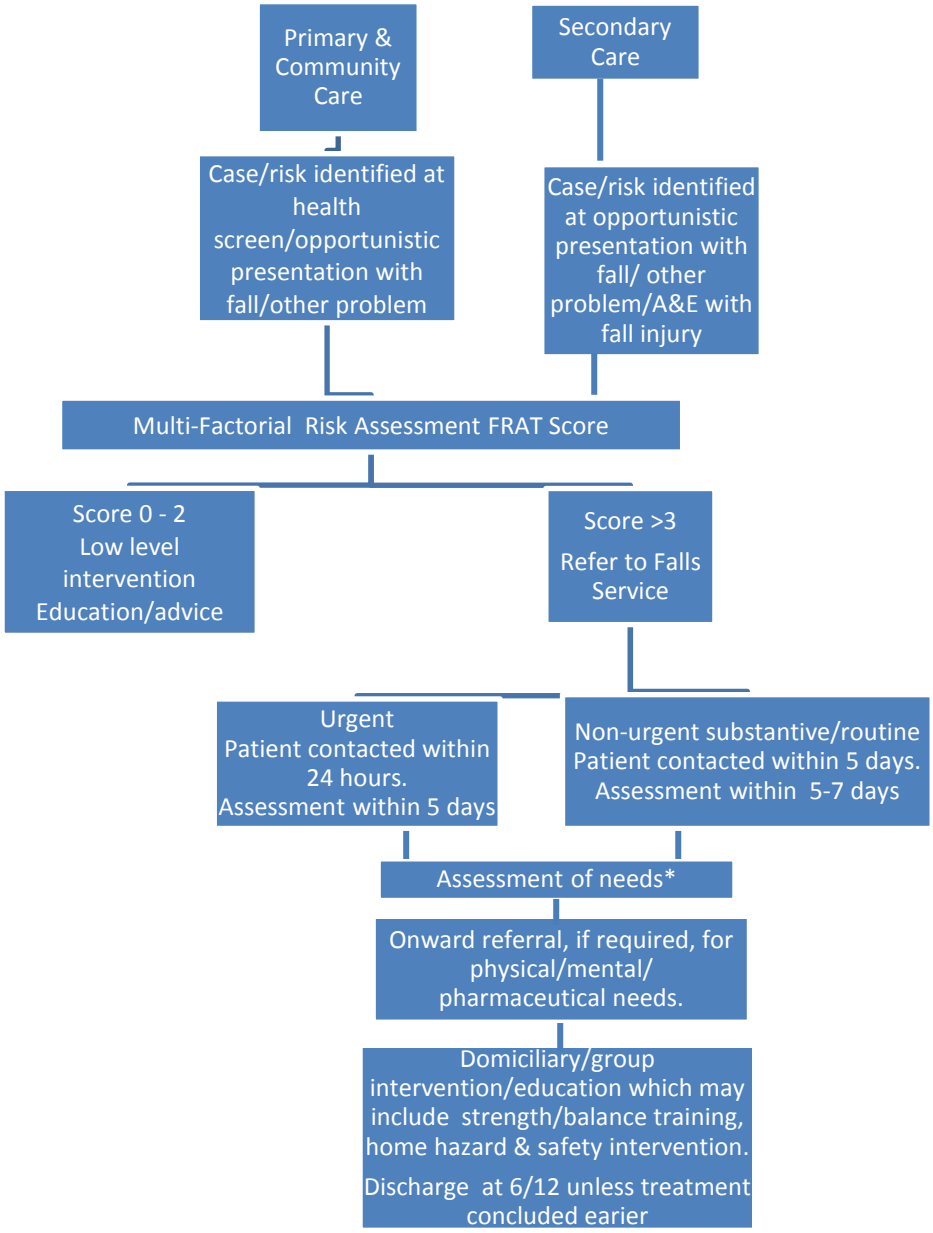
- Referral to treatment wait times
- Number of referrals received (source specific)
- Number of weeks each patient is in contact with the service
- The number of referrals not responded to within specified response times and reasons why
- Number of avoidable hospital admissions
- Number of expedited discharges
- Number of referrals rejected by the team, from whom and reasons
- Number of referrals seen
- Waiting times
- DNA rates
- Number of patients seen by different staff group
- Summary of educational/development input
- Patients offered relevant patient information
- Breakdown of incidents and complaints and outcomes

Key Performance Indicators

- PROMS Tinettie, Balance and Gait scores; Initial Assessment and Discharge
- Falls score – fear of falling
- Patient orientated goals at Initial Assessment 7 e.g. reduction in fear and number of goals reduced

Falls Pathway

Cannock Chase Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group



*** Multi factorial risk assessment to include;** Identification of falls history, Gait, balance and mobility, and muscle weakness, Osteoporosis risk, The older person's perceived functional ability and fear relating to falling, Visual impairment, Cognitive impairment and neurological examination, Urinary incontinence, Home hazards and Cardivascular examination and medication review.