

Draft Community Ear, Nose and Throat (ENT) Service Specification

**Date: 18th March 2015**

**Version: v0.11**

**Date:**<insert date that this version was created>

**Version:**<insert version control number>

### Date or version information

ent title

### Date or version information

|  |
| --- |
| Service Specification Document History |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Author | Release Date | Reason for change | Version # | Approval |
|  |  |  |  |  |
|  |  |  |  |  |

*Notes:*

*Draft versions should be numbered “Draft 0.1”, “Draft 0.2” etc. Approved releases should be numbered “1.x”, “2.x” etc.*

*Approval – this should be the person or forum responsible for sponsoring this work.*

Contents

[Date or version information 1](file:///V%3A%5CUSF%5CWest%5CNWSCA%5CGeneral%5CPlanned%20Care%20%28PC%29%20and%20Long%20Term%20Condition%20%28LTC%29%20Programme%5CPC%5CENT%5C2015-16%20service%5CSpecifications%5CSpecifications%20for%202016-17%5Cdraft%20ENT%20specification%2019.3.15%20v0.1.docx#_Toc414882528)

[Date or version information 1](file:///V%3A%5CUSF%5CWest%5CNWSCA%5CGeneral%5CPlanned%20Care%20%28PC%29%20and%20Long%20Term%20Condition%20%28LTC%29%20Programme%5CPC%5CENT%5C2015-16%20service%5CSpecifications%5CSpecifications%20for%202016-17%5Cdraft%20ENT%20specification%2019.3.15%20v0.1.docx#_Toc414882529)

[1.0 Aims 5](#_Toc414882530)

[1.1 Evidence Base for change 5](#_Toc414882531)

[For the remainder of the document ‘the service’ will refer to the community ENT service 7](#_Toc414882532)

[2.0 Scope 7](#_Toc414882533)

[2.1 Aims and Objectives of Service 7](#_Toc414882534)

[2.2 Service Model 8](#_Toc414882535)

[3.0 Out of Scope 9](#_Toc414882536)

[3.1 Services out of Scope 9](#_Toc414882537)

[3.2 Condition and Treatment Exclusions 10](#_Toc414882538)

[3.3 Incidental Cancer Pathways 10](#_Toc414882539)

[3.4 Semi-Elective Trauma 10](#_Toc414882540)

[4.0 Service Description/Pathway 10](#_Toc414882541)

[4.1 Self Management with Primary Care Support 10](#_Toc414882542)

[4.2 Community ENT Service 11](#_Toc414882543)

[Conditions to be included 17](#_Toc414882544)

[4.3 Medicines Management – under review 17](#_Toc414882545)

[4.4 Referrals to Secondary Care 18](#_Toc414882546)

[4.5 Discharge from the Service 18](#_Toc414882547)

[5.0 Interdependence with other services/providers 18](#_Toc414882548)

[5.1 Community 18](#_Toc414882549)

[6.0 Quality 19](#_Toc414882550)

[6.1 Patient and Carer Information 19](#_Toc414882551)

[6.2 Patient Experience 19](#_Toc414882552)

[6.3 Complaints and Plaudits 20](#_Toc414882553)

[6.4 Incident Reporting and Management 20](#_Toc414882554)

[6.5 Safeguarding the needs of Children and Vulnerable Adults 20](#_Toc414882555)

[6.6 Safety Alerts 20](#_Toc414882556)

[6.7 NICE Guidance 21](#_Toc414882557)

[6.8 Infection Prevention and Control 21](#_Toc414882558)

[6.9 Governance 21](#_Toc414882559)

[7.0 Outcomes and KPIs 23](#_Toc414882560)

[7.1 Critical Success Factors with Indicative Outcomes and Evidence 23](#_Toc414882561)

[7.2 Performance Report 23](#_Toc414882562)

[7.3 Minimum Data Set- Based on National Community MDS 23](#_Toc414882563)

[7.6 Local Quality Requirements (LQR) 23](#_Toc414882564)

[8.0 Equality, Sustainability (Environmental) and Social Value 24](#_Toc414882565)

[8.1 Equality 24](#_Toc414882566)

[8.2 Social Value 24](#_Toc414882567)

[8.3 Sustainability 25](#_Toc414882568)

[9.0 Armed Forces 25](#_Toc414882569)

[10.0 Thresholds 26](#_Toc414882570)

[11.0 Business Continuity 26](#_Toc414882571)

[12.0 Finance 27](#_Toc414882572)

[13.0 Estates 27](#_Toc414882573)

[14.0 Information Technology 27](#_Toc414882574)

[15.0 Workforce, training and Education 30](#_Toc414882575)

[16.0 Research, Audit and Development 32](#_Toc414882576)

[Appendix 1 33](#_Toc414882577)

[Appendix 2 33](#_Toc414882578)

[Appendix 3 33](#_Toc414882579)

[Appendix 4 33](#_Toc414882580)

|  |
| --- |
| 1.0 Aims |

This service specification sets out the criteria for the different parts of a ENT service needed to meet and deliver high quality care to patients.

This service specification has been developed by members of NHS Crawley, and NHS Horsham and Mid Sussex Clinical Commissioning Groups (CCGs) and Coastal West Sussex CCG in discussion with stakeholders, including clinical staff working in ENT Services, public and patients, other related services and commissioners. This also included a clinical stakeholder market engagement event. This specification builds on and develops the service and patient pathways originally in place for many years, this is the first procurement process for this service. This document aims to build on clinical best practice and provide flexibility for innovation.

### 1.1 Evidence Base for change

National

There have been a range of publications considering the opportunities to redesign some ENT pathways and services and providing more integrated services in community settings, closer to home.

• ‘Our Health, our care, our say – a new direction for community services’ (DH, 2006)

• ‘Shifting Care Closer to Home Demonstration Sites – report of the specialty sub-groups’ (DH: 2007)

National guidance and policy have also influenced key aspects within this service specification.

• National Institute for Health and Care Excellence (NICE) – guidelines and quality standards

• NHS Constitution – March 2013

• NHS Outcomes Framework 2014/15

• Francis Report – February 2013

The ENT service will carry out the service in accordance with best practice in health care and shall comply with the standards and recommendations contained in, issued or referenced as follows (or any updates to these areas of best practice):

* Issued by the Care Quality Commissioning & NHS Commissioning Board;
* The Health & Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and related Guidance).
* The Equality Act 2010 & Human Rights Act 1998.
* All legislation associated with infection control.
* Issued by the National Institute for Health and Clinical Excellence (including NICE CG 139 Infection: Prevention and control of healthcare associated infections in primary and community care).
* Issued by any of the British clinical royal colleges and BMA.
* Data Protection Act 1998.
* Child Protection Act 1999 / Safe Guarding Children 2008.
* DH Clinical Governance & Adult Safeguarding guidance Feb 2010.
* Freedom of Information Act 2000.
* Health & Safety, NPSA and MHRA legislation or directives - this includes but is not limited to policies in relation to managing musculoskeletal disorders (i.e. back problems), social care, stress, violence, incident reporting, infection control and latex allergies.
* Issued following any audit, Serious Untoward Incident or Adverse Incident Reporting.

The Commissioner requires that the service is receiving devices, or has access to a decontamination service that meets the essential requirements of the Medical Device Regulations 2002.

The Commissioner expects the service to be compliant with the essential quality requirements outlined in CFPP01-01 and expects the service to have a plan in place to achieve Best Practice. This plan should have been developed having taken account of the risk of surgical procedures.

The Commissioner reserves the right to ask for evidence of compliance with any aspect of this guidance throughout the duration of the contract.

A full list of references will follow.

Local

Crawley CCG, Horsham and Mid Sussex CCG, and Coastal West Sussex CCG “the commissioners” are committed to ensuring equity of patient access to community based, high quality ENT care.

The key aim of this specification is therefore to describe the core principles and the specialty specific standards required to deliver ENT in the heart of local communities, which means outside of the acute hospital setting for many patients.

The specification represents an invitation for innovation in terms of achieving pathway efficiencies with services provided from a range of community locations, ensuring access in semi-rural areas. Attention is drawn to the specific pathways that have been developed in partnership with the CCG planned care clinical directors and shared with the practices that should continue to be provided.

* Recurrent tonsillitis
* Adult hearing loss
* Nasal polyp
* Allergic rhinitis
* Discharging ear

Further pathways may be developed between the Service and Commissioners throughout the contract.

The Joint Strategic Needs Assessment (JSNA) for 2013 for each CCG summarises where there are concerns relating to population needs which include some of the issues highlighted.

The following table highlights the populations for each CCG area (taken from the JSNA 2013):

|  |  |  |
| --- | --- | --- |
| **CCG** | **GP population****(From Exeter June 2013)** | **Resident’s population** |
| Crawley |  127,258 (March 13) | 108,000\* |
| Horsham and Mid Sussex |  227,281 (March 13) | 223,000\* |
| Coastal West Sussex | 490,900 (March 13) | 480,000\* |
| Total | 354539 | 331000 |

\* From JSNA 2013

**Crawley CCG**

NHS Crawley CCG comprises of 13 practices within the Crawley area. There are fewer people in the 60 – 74 years age group than other areas of West Sussex, but it is the second highest percentage of the population. The highest is the younger working age people (25 – 34 years) which is also higher than England overall. Broadfield south ward contains the most deprived area of Crawley and this falls within the most deprived 20% of areas in England

**Horsham and Mid Sussex CCG**

NHS Horsham and Mid Sussex comprises of 23 practices within the Horsham, East Grinstead, Haywards Heath, Burgess Hill and surrounding geographical areas. This CCG area has an older age structure than England but there are fewer people in the young working age (20 – 34 years). However, both of these age groups are the highest percentage of the population.

**Coastal West Sussex CCG**

NHS Coastal West Sussex CCG serves a population of over 482,000; has an annual budget of around £600m is made up of 54 member GP practices working together to form six localities. We already have one of the oldest populations in the country with over 25% of the population over 65; by 2019 there will be 13% more people aged over 85 living locally. There are also wide inequalities between our communities; some local neighbourhoods have a life expectancy over 10 years shorter than their neighbours just a few miles away.

# For the remainder of the document ‘the service’ will refer to the community ENT service.

|  |
| --- |
| 2.0 Scope |

### 2.1 Aims and Objectives of Service

2.1.1 The Service will deliver:

* Right person, right place, first time.
* This model of care should be provided to patients that live within, or are registered at a GP practice that is within, NHS Crawley CCG and NHS Horsham and Mid Sussex CCG locality, and Coastal West Sussex CCG and achieve a consistent level of high quality Service.
* Co-create with Commissioners GP Clinical Care Pathways that describe what referring clinicians would normally do prior to referral into the service.
* Achieve care closer to home.
* Patients will have equal access to the service that offers consistent levels of service regardless of where they live within the CCG catchment areas and regardless of gender, age, ethnicity, disability, sexual orientation, religion or beliefs.
* Support the vision of community based and community led services that are developed through joint working between general practice and specialist clinicians and with in-reach to specialist care in acute settings, not outreach to the community.
* A service which ensures that the patient moves appropriately and seamlessly between primary, community and specialist secondary care services.
* Service users, including those from all 9 protected characteristic groups within the Equality Act 2010, (i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) feel the service is responsive to their needs.
* To support the care of the patient being in line with national guidance including NICE guidance and that published on the management of ENT conditions.
* When patients are referred onwards, that they arrive having had the appropriate work up in the pre hospital phase of their pathway within the agreed and defined time frame.
* Achieve improved health outcomes for patients.
* Achieve improved patient experience and high referrer satisfaction.
* Through referrer education GP’s and other healthcare professionals are supported to develop knowledge and skills in primary care ENT care.
* Ensure that commissioners have access to high quality performance metrics that support their commissioning intentions.
* Provide a clinician advice and guidance service by telephone/email within 1 working day for urgent, and 3 workings days for routine.
* Ensure patients have choice of provider if they require onward referral to secondary care.
* If a critical finding or suspicion of cancer were to inadvertently present at the service there will be a safe and locally agreed referral straight onto secondary care services with both the patient and the GP being immediately informed.

This document represents the minimum service specification required for all patients aged 2 years and over and registered permanently or temporarily with practices within the CCGs catchment area.

### 2.2 Service Model

2.2.1 The model of care will be underpinned by:

The vision for the service is one where the patient is placed at the centre of care and they receive a professional, sensitive and joined up quality service in a clinical setting appropriate to their need.

The following key service outcomes are expected to be delivered as part of the service:-

* The implementation of an agreed set of referral guidelines for GPs based on the evidence and co-designed with commissioners identifying what referring clinicians would normally do prior to referral into the service, to ensure the most effective patient pathway. Many of these co-designed pathways are already in place. These will continue to be reviewed and co-designed as the service develops. Rapid and effective triage of all ENT referrals using referral guidelines and the national/local cancer guidelines as a framework to direct the patient to the right person, right place, first time.
* Patients feel better able to manage their ENT condition.
* Delivering holistic care, including the identification and onward referral if required to meet the psychological and emotional needs of patients and their carers, so that the ethos of ‘no health without mental health’ is integral to all pathways; risk assessments, care plans and self-management approaches.
* Providing clinical leadership and case management where appropriate so that patients care is co-ordinated across the pathway.
* Implementing shared decision making so that the ethos of ‘no decision about me, without me’ is integral to all pathways. Ensure that good quality shared decision making takes place between the health professional and patient so that the patient makes an informed decision with their health professional based on good quality information about all the management options (including the use of NHS Right Care Shared Decision Making website).
* The Service needs to evidence that choice has been offered and clear and unencumbered referral pathways for those patients who require intervention from specialists in a hospital setting.
* Providing high quality performance information as defined by the specification to commissioners at prearranged and agreed intervals.
* If the referral is unclear or more information is required the provider will have a clinician to clinician conversation with the referrer within one working day, if urgent or within three working days if routine. Patients will have prompt access to specialist opinion, advice and treatment which is inclusive of a GPSI ENT.
* Care will be delivered where possible in a one stop shop, by providing care that minimises the number of appointment visits for patients. This can be achieved by locating staff together and by amalgamating appointments so that patients can be assessed, undergo diagnostic tests, receive the results and the diagnosis and be provided with a treatment plan which includes surgical management if appropriate within a one-stop shop if appropriate. NB the ENT must ensure they have access to hospital pathology lab results and imaging to ensure a seamless service for the patient and avoid duplication of investigations.
* Patients and clinicians will have prompt access to routine diagnostic tests and to the results.
* Supported self-care will be delivered through much greater access to patient and carer education, advice and support services throughout the area.
* All patient records are electronic and maintained and secured in line with national guidance and local policies (e.g. Data Protection, Caldicott, confidentiality etc).
* Ensure the patient’s GP is informed of the outcome of any appointments as outlined within the national contract.
* Clear and accessible patient information will be provided in a variety of formats including guidance on services provided and health promotion for common ENT conditions. The patient will be provided with both verbal and written information to improve their understanding of their health condition and management.
* Provide routine advice and guidance service within 3 working days for non-urgent requests and within 1 working day for urgent requests, by email or telephone, to clinicians and patients currently in the Service;
* Provides SOS/telephone services for patients self-referring back into the service within 6 months of discharge for the same condition.
* Provide a Consultant supported community ENT service. The Consultant provides advice and guidance to the Community ENT team as well as clinical supervision and support.

The service should be provided in line with the patient and public rights and the values set out within the NHS Constitution. This includes:

* Rights and pledges covering access to health services;
* Rights and pledges covering quality of care and environment;
* Rights and pledges covering nationally approved treatments, drugs and programmes;
* Rights and pledges covering respect, consent and confidentiality;
* Rights and pledges covering informed choice;
* Rights and pledges covering involvement in your healthcare and in the NHS; and
* Rights and pledges covering complaints.

These rights and pledges are set out in the Handbook to the NHS Constitution on NHS England website at [www.england.nhs.uk](http://www.england.nhs.uk)

|  |
| --- |
| 3.0 Out of Scope |

### 3.1 Services out of Scope

No surgical procedures requiring general anaesthetic will be carried out in this service.

The service will not include:-

* Suspected cancers (2 week rule)
* Lumps in Neck/Thyroid
* Sudden, or unilateral hearing loss,
* Age related hearing loss in those aged over 55 years (refer to Direct Access Audiology)
* Hearing difficulty in children (refer direct to Children’s Hearing Services)
* Dizziness or vertigo
* Unilateral Tinnitus
* Sleep Apnoea/Snoring (unless direct access to sleep studies)
* Foreign body in ear, nose, or throat
* Dizziness/Vertigo(refer to Balance Services if available)
* The Provider will not undertake any actions or procedures which are identified as low priority by the NHS Sussex Priorities Committee

### 3.2 Condition and Treatment Exclusions

In addition, the following exclusion criteria apply:

Complex and urgent (red flag) referrals including suspected cancers will be directed to an acute hospital service by the patient’s GP.

### 3.3 Incidental Cancer Pathways

The Provider should work with and keep up to date with the national guidance and policy covering service standards, national cancer waiting time targets and referral guidelines. They should work with both the Cancer Strategic Network and National Cancer Intelligence Network, participating in peer review and audit.

Incidental cancers: Patients with suspected cancer should be referred under the 2 week rule direct to the relevant service and are not referred to the ENT service.

Unexpected cancers: in the event that an unexpected cancer is found when carrying out or reporting a routine procedure and within 2 hours of discovering the condition, the clinician should ensure that:

* the procedure is reported urgently
* the patient is informed urgently
* The patient must be referred onto an appropriate cancer pathway
* An email or fax should sent immediately to the GP and the referrer (if this was not the GP) outlining the outcome of the report and the referral
* The commissioner expect the Service to have locally agreed referral pathways with secondary care providers to ensure any onward referrals are made in a timely, effective way without delay and to allow an urgent referral to be made to an acute provider which can be converted once received on to a 32 day pathway.

The Service needs to ensure immediate electronic referral, with acknowledgement of receipt from the provider of cancer services (i.e. ensuring fast and safe clinical governance). In addition the Service needs to ensure immediate notification to the GP by email/fax and immediate notification to the patient with explanation

### 3.4 Semi-Elective Trauma

Foreign bodies in ear or nose will not be seen by the Service (see exclusion criteria)

|  |
| --- |
| 4.0 Service Description/Pathway |

### 4.1 Self-Management with Primary Care Support

*4.1.1 Promotion patient self-care and self-management functions:*

The use of self-care must be promoted by the Service for patients through education and agreed supported self-management plans. The Service will support GP’s and other health professionals in providing appropriate ENT patient information, and signposting to other services to enable the patient to manage their condition appropriately prior to referral.

The Service should pro-actively promote patient self-care and self-management. This should include the following:

* Development and or active usage of condition-specific guidance for the management of conditions through self-care, supporting patients and primary care practitioners to follow this guidance.
* The use of personalised care plans (that can be shared between GP, patient, and other services as appropriate) that clearly outline how the patient should self-manage e.g. advice on condition flare up.
* Develop patient support groups led by specialist nurses, as appropriate.
* Improve patient education by a range of media to include development of education courses, signposting to validated e-learning sites and supply written information.
* Improve patient access to information in different media, e.g. websites, leaflets or help lines.
* Together with the patient, review them holistically and how this may affect their ENT condition, refer when appropriate to Health and Wellbeing Services for healthy lifestyle support, social support as well as psychological support through referral to Time to Talk Services.

The Service will develop a website for patients, carers and healthcare professionals that will provide educational tools, such as information leaflets and videos. These should be patient friendly written in plain language with availability of translation services when required.

A variety of tools and techniques that can support patient information should be utilised to ensure that patients understand their conditions, what the treatment plan may be and that they are involved along the pathway of care.

For children 2 years and older supporting their and parent/ carer understanding of their ENT condition and how it can be managed more effectively during changes of age and in lifestyle will enable self-management into adulthood.

Self-management will be promoted and the importance of compliance with treatment regimens will be emphasised. It will be made clear to patients from their first appointment that it is expected that they will be discharged from the Service i.e. they will not stay on the Service’s case load indefinitely but rather from the beginning of their care, the Service is working towards a safe discharge after effective care where clinically appropriate.

On discharge from the Service, a self-management plan is agreed with the patients. This will describe the patient’s self-care action plan and a copy will be held by the patient, the GP, as well as the Service. It will be inclusive of maintenance, and flare management advice and will be stored electronically where possible.

Following a period of ENT treatment, a patient will be able to self-refer back via a telephone consultation initially (or any other appropriate method as agreed with the patient) with the Service if the same condition recurs within a six month period.

4.1.2 Primary Care Support

The Service will work closely with the GPs and primary care clinicians to enable over time that the quality of referrals into the service should continuously improve.

To support and assist GPs in making effective and appropriate referrals both in to the community ENT service and via the 2 week referral pathway, the Service will provide support via: development and use of condition-specific guidance for the management of conditions in primary care; training programmes and other forms of support; and specific advice and guidance to General Practitioners.

### 4.2 Community ENT Service

The service provides:

* One-stop clinical assessment, diagnostics, shared decision making, advice and support. Appointments must be long enough to allow the patient time to ask questions and receive responses.
* Integrated psychological approaches to patient care through screening & assessments and appropriate interventions by suitably qualified staff with referrals to specialist psychology services such as Time to Talk, where appropriate.
* Minor Operative Procedures completed by a competent clinician and conducted in a way that ensures maximum comfort and minimum risk for the patient. Informed patient consent for any surgical interventions.
* Alternative methods of consultation, including telephone consultations, email and a telephone advice line
* Fully manages the sequence of care including onward referral and choice.
* Full diagnostic service including blood sampling, microbiology, ultrasound, CT scan, and management of the results (see 4.2.6.2). The Service must have access to hospital pathology lab results and other investigations e.g. ultrasound by AQPs.
* Patient advice and education including patient friendly materials and personalised treatment plans.
* Limited prescribing in line with commissioner approved formulary. In the event of a patient requiring medication, patient information must be made available and the patient informed to see the GP for prescription, allowing for the usual time frames. If a patient requires medication urgently then the service will provide the medication (see section 4.3).
* Discharge summary for the patient’s GP as required within the national contract.
* Multidisciplinary Team Working- the GPSIs will actively work within the Multidisciplinary Team seeing patients and supporting genuine multidisciplinary working.

The assessment for procedures should be conducted with the patient and recorded and include as a minimum:

* Patient demographics
* Protected characteristics
* Appropriate medical history
* The patient understanding of their condition and any procedure/treatment to be carried out
* Medical condition on arrival
* Mental capacity

Patients must be offered the option of a chaperone for any examination. The definition of intimate or invasive may differ between individual patients for ethnic, religious or cultural reasons.

The Provider should be aware of the weight limit for examination couches and trolleys and ensure that the appropriate equipment is available or make suitable alternative arrangements when necessary.

4.2.1 Referral process

**NHS Crawley and NHS Horsham and Mid Sussex CCG Referrals**

Referrals to the Service will be able to be sent electronically, but this is not mandated as yet.

An electronic referral process will also facilitate Choose and Book or equivalent service and the audit of activity. In addition electronic referrals will allow triage, ensuring patients see the right person at the right time in the right place. Providers must be able to receive referrals from other sources – as a minimum, referrals should be sent/received by secure email.

All referrals, whether from a GP or other health care professional, will be treated as a GP referral for the purposes of delivering a maximum 18 week wait.

The commissioners will require the Service to agree referral guidelines and inclusion/exclusion criteria with the CCG Planned care clinical directors and to communicate these to their referring GPs. Referral guidelines should be consistent with guidelines already in place within the CCGs, where these exist.

The ENT service is a single point of access for GPs and other Health Professionals into the Service and choice of secondary care provider will be offered if specialist hospital care is required.

**NHS Coastal West Sussex CCG Referrals**

All referrals to be accepted by e-Referral, this is in line with the roll-out of e-Referral across Coastal West Sussex CCG. Referrals should be triaged within 2 workings days of receipt.

All referrals, whether from a GP or other health care professional, will be treated as a GP referral for the purpose of delivering a maximum 18 week wait.

The commissioners will require the Service to agree referral guidelines and inclusion/exclusion criteria with the CCG planned care clinical directors to communicate these to their referring GPs. Referral guidelines should be consistent with guidelines already in place within the CCGs, where these exist.

The ENT service is a single point of access for GPs and other Health Professionals into the Service and choice of secondary care provider will be offered if specialist hospital care is required.

4.2.2 Patient Access

The Service provider must demonstrate that they are able to offer a service for 52 weeks of the year and that clinics provided by the Service are offered on different weekdays (with a move towards 7 day working) to enable flexible access for patients.

The commissioners wish to commission improved timely access to services, including:

* Decreased waits for appointments, both first and follow up.
* More appointments offered as one stop appointments.
* Patient access to telephone follow up.
* Patient access to appointments outside of normal working hours, normal working hours being 9-5pm for the purpose of this document. This could include access to services before or after working hours and/or weekends.
* For those patients who, following face to face assessment, are identified as requiring onward referral to hospital based services then a maximum handling time within the Service of 4-6 weeks with 6 weeks as the maximum.
* Much improved signposting to relevant education and support services early in the patient pathway, including the voluntary sector support groups.

The Provider will provide appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read or write English or who have communication difficulties, in order to:

* minimise clinical risk arising from inaccurate communication;
* support equitable access to healthcare for people for whom English is not a first language; and
* support effectiveness of service in reducing health inequalities.

The service will also need to make appropriate provision for local patients who are travellers or have no fixed address. The service is available to all patients of 2 years or over irrespective of race, religious beliefs, disability, ethnicity or sexual orientation. The availability of the Service should be flexible to reflect the needs of the working and elderly populations including all hard to reach and vulnerable groups.

4.2.3 Clinical Care Pathways

All referrals, whether from a GP or other health care professional, will be treated as a GP referral for the purposes of delivering a maximum 18 week wait.

The Commissioner has a range of GP/clinician co-designed referral clinical pathways in place and other professional clinical pathways. These describe an expected assessment; work up and management of the patient; prior to referral; and the referral destination. It is recognised that these pathways will need to be adapted in the light of the Service and pathways where not in existence now will need to be developed in conjunction with the Commissioner. These GP/clinician co-designed clinical referral pathways should be evidence based and describe what referring clinicians would normally do prior to referral into the Service, to ensure the most effective patient pathway.

Many of these co-designed pathways are already in place. These will continue to be reviewed and co-designed as the service develops. Once agreed, the Service will be expected to triage all referrals against these pathways and to triage back where there is insufficient information on which to complete the triage process. This will be done by peer to peer contact i.e. if a clinical issue is found with a referral the discussion with the referring clinician will be carried out by a clinician within the service. This must be carried out as soon as any deficiency in referral is found to ensure that the patient pathway is not delayed and also as learning is best achieved when the referral is current. This discussion must be carried out in a supportive way to enable the personal and clinical development of the referring clinician. If an administrative deficiency is found in a referral there need not be a clinical discussion.

There is recognition that not every individual patient fits into a pathway so they should be used as guidance and not as absolute protocols.

The Service will work with the Commissioners to develop standardised referral formats where the Commissioner thinks appropriate.

4.2.4 Shared Decision Making

The Service should use innovative ways of providing information and resources for patients and their carers, for example use of information websites and links to patient organisations and support groups as well as Carer Liaison Services.

At all stages of the pathway, patients will be given/sent copies of letters and reports with covering explanation if needed.

Shared Decision Making is an essential requirement of the Service. National Patients Decision Aids, (from the Right Choice NHS Website, where available), should be used to assist with this process so that all patients are aware of the management options available to them and the advantages and disadvantages of each option.

4.2.5 Activities to be performed

* To support GP’s with education and advice to enable patient care to be able to be provided in primary care where clinically appropriate.
* Continue to develop agreed pathways and shared care arrangements with local GPs for the management of ENT issues.
* Provide advice and guidance service to clinicians and telephone service for patients where appropriate in the form of email and telephone.
* Through education and support to primary care to ensure that referrals to the Service are apt.
* Keep the GP and the practice fully informed of all decisions relating to the patient’s care in a timely manner within 7 working days, this includes clinic letters.

**4.2.5.3 Triage Gateway:**

Triage will be carried out by appropriately trained and qualified specialist clinicians. Specialist is defined as a GPSI ENT or experienced clinician(s) working within the community ENT team. Typically these clinicians will have the sign off of the GPSI to fulfil the role and/or can provide evidence of competence, and is supported by an ENT Consultant as part of the Service.

This will be achieved within 1 working day depending on potential condition and patient needs. Triage must result in the patient being directed to the right person, right place, first time. Triage will prioritise the referral with outcomes to include:

* Directing patient back to their GP with advice for primary care management.
* Rapid GP access to expert opinion/advice and guidance from a range of clinicians within the multidisciplinary team.
* Directing patients for assessment and/or diagnostics within the multidisciplinary team, following the referral guidelines and in compliance with NICE guidelines.
* Directing patients that are clinically appropriate straight to secondary care following the use of SDM and patient choice.
* Real time feedback to or to gain further information from referring clinician.
* Capturing referrals that are re-directed back to the referrer should be reported to the Commissioner (on a monthly basis) so that any potential issues may be reviewed and issues can be addressed through education and support.

**4.2.5.4 Booking Appointments:**

The service will contact the patient to offer and agree with the patient a time, date and place for their appointment and discuss any special needs that they have.

**4.2.5.5 Multidisciplinary Team Working:**

The GPSI will actively work within the Multidisciplinary Team seeing patients and supporting genuine multidisciplinary working. GPSI will be co-located with other MDT members within the clinics to avoid misdiagnosis, support the members of the team and facilitate listing for procedures. The Service needs to ensure that face to face regular meetings as an MDT occur to agree treatment and ensure best practice pathways of care. It needs to ensure collaborative working, agreeing a management plan in conjunction with the patient and the need for all patients to have information about their condition in a form relevant to their learning style.

**4.2.6 Treatment function**

**4.2.6.1 Clinical Assessment and Treatment function:**

* Rapid access to clinical assessment, treatment and advice; this is inclusive of rapid diagnostics to support a one stop clinic and nurse-led microsuction clinics, both with supervision from the GPSI in ENT.
* Clear protocols for the management of urgent referrals that require onward referral to hospital based ENT services.
* Fully manages the sequence of care, from initial referral through to discharge from the service. This could include referral to diagnostics and directing the patient to other specialties in primary or secondary care. The service should provide pre-operative assessment and required work up of the patient as per NICE guidance for all community surgical procedures including MRSA, swabs, relevant bloods etc.
* Provides access to a clinical laboratory support service for the diagnosis of ENT conditions and access to a phlebotomy service.
* Provides treatment e.g. medication according to an agreed formulary.
* Provides follow up appointments, either face to face, by telephone or other media sources, as agreed with the patients.
* Provides signposting to patient support services early in the patient pathway for example Health and Wellbeing, Time to Talk services.
* Offers choice of Provider.
* The service will provide treatment in line with accepted clinical protocols and best practice and clinical standards (e.g. See NICE Guidance; SIGN guidance; The British Association of Otorhinolaryngolgoists - Head and Neck Surgeons (ENT UK) at the Royal College of Surgeons’ Guidance; DH Commissioning Pathways).
* The service will offer support and care plans for self-care including for example, better aural care; dealing with ear-wax; sources of support (e.g. for smoking cessation), and care plans.
* The service will signpost voluntary and charitable (third sector) organizations who may offer further information and support.
* The service will provide Direct Listing to surgical treatment waiting lists when required (e.g. tonsillectomy) or, triage directly to secondary care if Direct Listing is not available (to avoid unnecessary extra steps and costs in the patient pathway) offering patients choice of secondary care provider.
* Where Direct Listing for surgery is available, the service may provide appropriate preoperative assessment at the time of decision to admit, using agreed protocols; and an appropriate written process including initiation of consent should be agreed between the surgical team and the interface ENT service.
* A Consultant in ENT supports the clinical assessment and treatment functions.

**4.2.6.2 Diagnostics** The service will provide the following diagnostic services and interventions in a one-stop setting wherever clinically appropriate:

* Microbiology
* Blood sampling

The service should have access to the following;

* Ultrasound
* CT scan

Expected turnaround of diagnostic tests such as bloods is 5 working days. The service must be able to review previous diagnostics and blood test results completed in primary care prior to referral.

The Service will ensure that (and provide evidence to the commissioner if asked):

* Written consent must be obtained for all patients having surgical interventions in compliance with General Medical Council standards.
* Treatment of minor complications following surgical interventions undertaken by the Service will be the responsibility of the Service. For any other complications or problems the GP may refer back to the service for either telephone advice or for the patient to be seen as an urgent at the next clinic. Re-referrals following discharge for complications post treatment will NOT be charged.
* There will be a set cost for a nurse led microsuction clinic, irrespective of the number of the times a patient requires microsuction. This nurse led clinic will be supported and run alongside GPSI clinics.
* The case notes of patients who DNA will be reviewed to determine whether referral should be returned to the referring GP or a further appointment is offered. The Provider needs a system in place to reduce DNA rates, such as text reminders. **DNAs will not be charged in the contract**.
* The unit and all staff are trained and competent to manage patients appropriately in the event of cardiac arrest, respiratory arrest, or anaphylaxis.
* The competency and availability of staff to meet the needs of patients which fall within the clinical conditions included in this specification, including working with vulnerable persons. Local and national guidelines will be followed with staffing changed to reflect any new guidance released.
* Robust risk management, complaints, infection control and untoward incidents reporting mechanisms are in place and being followed by all staff.
* Information is available for patients, in a range of formats and languages appropriate to the local population. The information should include the outline of the services, together with patient information leaflets giving details about their clinical conditions and any treatment advice.
* Post invasive treatment the patient and carer will be given an information leaflet that includes signs and symptoms of infection and the appropriate action and outlining the post discharge surveillance scheme.

**4.2.6.3 Integrating Psychological Approaches to Assessment and Treatment**

The Service’s Clinician’s will complete a holistic assessment of patient’s needs and address psychological aspects relevant to their ENT condition by referral to local IAPT Services such as Time to Talk, ensuring the patient’s GP is informed.

4.2.7 Pathways

## Conditions to be included

The service provider will be expected to provide a service which could see all routine, non-urgent (non red flag) referrals of patients aged two years and over from the list of conditions below:

Depending on history at triage, specific conditions to include but not be limited to:

* Unresolved otalgia,
* Otorrhoea - acute or chronic otitis externa
* Chronic suppurative otitis media (**but** red flag urgent referral to secondary care ENT dept if associated with vertigo, headache or facial palsy)
* Otitis media with effusion
* Recurrent otitis media
* Routine cleaning of mastoid cavities (for those who have had mastoidectomies)
* Conditions requiring aural toilet after failure of primary care conservative treatment, or for whom ‘ear syringing’ is contra-indicated
* Nasal obstruction
* Recurrent epistaxis, and cautery
* Acute and/or chronic Rhinitis/Rhinorrhoea
* Check for nasal polypi,
* Recurrent sore throat
* Globus, throat discomfort, or ‘feeling of something in the throat’
* Chronic sinusitis
* Query Cholesteatoma
* Tinnitus (but see exclusion below)

Procedures to be performed include but are not limited to:

1. Microsuction
2. Nasal Cautery
3. Nasoendoscopy
4. Hearing screening

### 4.3 Medicines Management – under review

### 4.4 Referrals to Secondary Care

4.4.1 Onward Referral for Non-Surgical Care

The initial point at which choice is offered is at onward referral from the Service. The Service is a multi-disciplinary team approach in which the GPSI ENT is a member of and hold their own clinics. Staff are supervised and supported by a Consultant ENT surgeon as per the NHS Constitution. Where a Consultant led outpatient appointment is required, patients should be offered choice at the point of referral and given the necessary information and support to help them make a decision as to where they choose to have their care.

### 4.5 Discharge from the Service

Discharge occurs when the community clinician reaches a stage where no further action will take place with the patient’s referral. The patient is directed back to the referring GP or healthcare professional.

At the point of discharge from the Service, the Service will be required to produce an electronic discharge document that will contain an account of the assessment, diagnostic tests, treatment plan, treatments carried out and outcomes from the service. It must also include any medications started, stopped or adjusted with the reason on the discharge summary.

The aim is that the referring clinician should receive this information electronically not later than 24 hours (National Standard), after the patient being discharged from the Service. It would include an on-going supported self-management plan (personalised care plan) that has been agreed with the patient. This will describe the patient’s on going self-management plan and a copy will be held by both the patient and the GP. An SOS system to enable a patient access back by telephone initially into the service within a six month period will also be provided for the same condition. This will support patients, including managing flares of their condition, thus reducing attendance in Emergency departments. The Service will develop a liaison with return to work support schemes locally such as work choice and work programme to support patients to return to work or develop new job skills as appropriate, accessed via Health and Wellbeing Services.

The report must be documented in the patients records, communicated to the patient in a legible and clear format, the GP and to relatives/carers as appropriate, and should form part of any onward referral.

For patients who are suitable for primary care management the service will refer back to GPs with a management plan. The service will also be available for other support i.e. telephone advice, to support the GP. The discharge summary will provide GPs and other healthcare professionals advice on referring back in to the service if required.

|  |
| --- |
| 5.0 Interdependence with other services/providers  |

### 5.1 Community

**5.1.1.Interdependence**

The majority of patients will be referred by and then returned to the care of their usual GP. A small number of patients may have serious pathology identified and they will require onward referral to secondary care.

Key interdependencies include:

* GPs
* Secondary Care
* Children’s Hearing Services
* Paediatrics
* Care of the elderly
* Falls Service
* Audiology and Audiological medicine
* South East Coast Cancer Strategic Clinical Network

It is expected that there will be robust relationships with the acute consultants to support integration and streamline the pathway.

|  |
| --- |
| 6.0 Quality  |

### 6.1 Patient and Carer Information

The Service will provide clear and detailed information to patients to support an informed patient pathway. A variety of current and innovative methods of conveying patient information will be developed that GPs and health professions within the Service can share with patients in primary care, e.g. patient leaflets and websites. Methods will be available in a format that takes into account patient needs, e.g. in different languages.

Patients will be sent full personalised information prior to any appointment to maximise the health gain obtained at any appointment. This would include a time, date, place and directions or the ability to arrange this at the patient’s convenience.

The information should also include the role of the person or persons that the patient will meet, any questions that they might be asked, what might happen at the appointment and so on. The Service should also provide information about the service and send reminders of appointment via email or SMS to reduce incidence of DNAs.

Where patients express a positive preference, communications should be by e-mail. The Service should use innovative ways of providing information and resources for patients and their carers, for example use of information websites and links to patient organisations and support groups as well as Carer Liaison Services. At all stages of the pathway, patients will be given/sent copies of letters and reports with covering explanation if needed.

Shared Decision Making is an essential requirement of the Service. The National Patients Decision Aids should be used to assist, if available, with this process so that all patients are aware of the management options available to them and the advantages and disadvantages of each option.

### 6.2 Patient Experience

The Commissioner expects the Service to develop and implement patients’ experience surveys including ‘Real time Patient Surveys’. These surveys will include:

* Regular evaluation reports detailing the results of the surveys including the key themes that are emerging and the delivery of action plans to address concerns and issues raised by patients, service users and carers;
* This will also include the Patient Reported Outcomes Measures (PROMS) and any other similar tools for other conditions as defined by Commissioner. The usage and evaluation and further design will be developed through continued clinical stakeholder engagement;
* Distribution of the report to Commissioner and patients;
* Evidence of active and continual patient and carer involvement in the review and redesign of service provision;
* Evidence of real time patient experience;
* Evaluation of Shared Decision Making; using SURE scores;
* Compliance with requirements of the Friends and Family Test initiative;

###

### 6.3 Complaints and Plaudits

There must be clear routes for patient complaints and plaudits and for staff to raise patient safety and service concerns:

* The Service will be able to demonstrate that the complaint handling process is clear and accessible. The Complaints Procedure will clearly lay out timeframes for action. All complainants will receive an acknowledgement within 3 working days and a formal response within 25 working days. The Complaints Procedure should be clearly signposted so all patients and staff are aware how to access it. It will also outline the process of implementing any learning that may arise;
* The Service will utilise a soft intelligence tool for patient/carer/worker within the Service to use to report any plaudits or concerns;
* The outcomes of Service user involvement will demonstrate improved health and quality of life for patients and improve experience of the whole pathway.

###

### 6.4 Incident Reporting and Management

The Service will have a system in place for raising, recording and managing patient safety Incidents (PSIs) and Serious Incidents (SI), in line with national and regional policies and frameworks laid out by the National Patient Safety Agency. Each SI will be followed up by a formal investigation and action plan with the Commissioner being updated on progress. There will be evidence of Board to floor capacity and capability, measuring quality and safety management practices.

The Service will ensure that there is a process for all SIs either directly or sub-contracted are logged on the national STEIS database and Root cause analysis (RCA) submitted to the Commissioner for review of recommendations and action plans to inform and improve practice.

The Service will have an Incident Policy in place. An annual report of all incidents will be submitted to the Commissioner. This annual report should include evidence of undertaking learning from the incident and how learning from incidents has led to change in practice.

###

### 6.5 Safeguarding the needs of Children and Vulnerable Adults

The service will ensure it meets the statutory requirements and national policy drivers for safeguarding children and adults, including specific roles for named and designated leads. Safeguarding Children requirements are mandated by law for people aged 17 years and under, so the service will be required to meet required national standards. The service will have processes in place to ensure staff are trained to the required levels and there is a process in place to ensure staff know how to raise Safeguarding alerts, and (for adults) complies with the pan-Sussex Multi-Agency Policy and Procedure for Safeguarding Adults at Risk, and equivalent processes for Child Safeguarding.

### 6.6 Safety Alerts

The Service will have a system in place to ensure national safety alerts (including medicine alerts, medical devices, estates and facilities) are received, disseminated and implemented in line with the required actions.

### 6.7 NICE Guidance

The Service will have in place a system, agreed with commissioners, to ensure compliance with NICE guidance and updated technical appraisals relevant to the service are reviewed and applied as appropriate to the service.

### 6.8 Infection Prevention and Control

The Service, together with any other sub-contracted services will ensure risks in relation to the prevention of Health Care Associated Infections and communicable diseases are minimised. There will be effective clinical leadership to ensure required standards are met to control and prevent infections acquired in care.

Providers must comply with all national legislation or regulations referenced in the specification or attachments.

* + - * Irrespective of the physical location of the clinics the service should have the same outpatient equipment available to examine the patient as recommended by ENT UK (British Association of Otolaryngologists-Head and Neck Surgeons) 2008.
			* The service must comply with the specific ENT – UK requirements for room space, decontamination of instruments and audiological support.
			* It is the responsibility of the service to purchase, calibrate, maintain to a high standard and replace all relevant equipment required to provide the service.

Equipment required includes sufficient provision (but is not an exhaustive list) for the activity level for:

* + - * Aural examination and toilet with microscopy and suction.
			* Nasal and pharyngeal endoscopy.
			* Facilities for decontamination and reprocessing of nasendoscopes and other instrumentation.
			* Tracking and traceability of all equipment detailed within patient records.
			* Photo-documentation for medical records and information transfer.
			* Disposable instruments preferred.

Decontamination of Nasendoscopes (HTM01-06) has been reviewed and re-launched by the DH. The Commissioners expect the community providers to adhere to best practice with the single use of nasendoscopes per patient.

If providers do not adhere to the appropriate Directives for Decontamination, the CCG reserves the right to give immediate notice on the contract.

### 6.9 Governance

The Service will have an established Clinical Governance programme and share key clinical governance information with the Commissioner in the form of an annual report which covers any audits undertaken against the standards set within the policies described above and in addition, the following:

* Patient, public and carer involvement;
* Staff management and performance, including recruitment, workforce planning and appraisals;
* Education, training and continuous professional development for all staff; (this includes the recording, and submission to the commissioner of these records if asked, of attendance of mandatory training for all staff);
* Clinical effectiveness, incidents, near misses, complaints and audits;
* Communication both internal and external;
* Leadership development at all levels of the organisation. The lead GPSI in ENT will be involved in developing and implementing the service level clinical governance programme;
* Information governance;

The Service will share key clinical governance information with the Commissioner and the Service will act on any recommendation in any Care Quality Commission report that the Independent Regulator requires to be implemented or is otherwise agreed by the parties to be implemented. Results and recommendations from annual Care Quality Commission audits will be built into a programme of continual improvements.

Within the Service a lead GPSI ENT will have overall responsibility for supervision for other professionals, as appropriate, delivering the service to maintain practitioner competence and support service integration. A GPSI will be accessible to clinical staff for any urgent issues which may arise during clinics either directly on hand (preferred) or via telephone or email. The Service will be supported by a Consultant in ENT.

The Service will have operational systems to support the following principles:

* Clear lines of responsibility and accountability.
* A programme of quality improvement activities.
* Clear policies, procedures, clinical protocols, patient group directions and algorithms aimed at managing risk and remedy poor professional performance.
* Develop and maintain a clinical network to support the MDT. This network will hold regular meetings to review outcomes, discuss challenging cases and critical incidents, provide peer review and discuss areas of unmet need or Service development. These meetings will be core to maintaining a high quality delivery of clinical services.

A programme of audit and review will be undertaken at predefined intervals to monitor service standards, outcomes and patient satisfaction and the results shared with the commissioner. The service is expected to participate in any National Audits as appropriate.

The Service will have a framework that assures patient and staff safety and is supported by a range of policies and strategies as outline in the list of policies applicable to this procurement offer.

The Service will ensure that a process is in place to carryout DBS checks on all staff as legally required and annual professional registration checks are carried out for all clinical staff. All doctors will be registered licensed practitioners. In addition, the provider will have systems and processes in place to ensure all clinicians have undergone re-validation as required by their professional body. Evidence of this re-validation may be requested by the commissioner

The Service will be responsible for ensuring that GPSIs have been assessed as competent, hold current professional registration and indemnity insurance and who also meet the following criteria;

* Undertake annual peer supervision.
* Maintain a professional development logbook, recording, practical supervision received, courses attended and other related further education.
* Be in receipt of feedback on performance.
* GPSIs are required to meet the RCGP and RCS accreditation requirements.
* A GPSI in ENT must possess a subset of ENT skills and can deliver a service to meet the needs of patients with specified ENT conditions. GPSIs are required to have a minimum of a Diploma in Otolaryngology – Head and Neck Surgery (DO-HNS).
* Nurse led microsuction clinics are supported by the GPSI in ENT.
* Undertake one clinical audit relevant to the service every year.

|  |
| --- |
| 7.0 Outcomes and KPIs |

Providers will be required to comply with all National Quality Requirements set out in Schedule 4 of the NHS Standard Contract, these can be found at [www.england.nhs.uk/nhs-standard-contract](http://www.england.nhs.uk/nhs-standard-contract). Bidders will be required to sign up to all terms and conditions of the Standard NHS Contract including the operational and national performance indicators.

### 7.1 Critical Success Factors with Indicative Outcomes and Evidence

Clinical outcomes are an emerging field and the community ENT providers will work with the Commissioner to agree measures and development of these over the life of the contract. Also see Local Quality Requirements on Appendix 1 (to follow).

### 7.2 Performance Report

To support on-going monitoring a monthly Performance and Quality Report will be required. This report should be an integrated single report containing all required information. The Service will act on remedial plans on a monthly basis

It is expected that the specific content of the report be agreed between commissioners and the Service prior to service commencement, notwithstanding, it is expected that this is an iterative report which will be subject to regular review and rationalisation as the service matures.

The Service will also provide an annual report or ‘quality account’ which summarises the quality outcomes of the Service for the previous year, and describes what the Service will do to maintain and/or improve quality. This will be based both on what quantitative data, as well as other qualitative information in relation to what patients and the public are saying about their experience of the Service.

### 7.3 Minimum Data Set- Based on National Community MDS

The service minimum dataset is collected to fulfil both local and national requirements.  The data contains patient level data about Patients, Referrals, Care Contacts, Diagnostics and administrative processes.  Data should be provided in accordance with national information governance protocols.

It is anticipated that this data will primarily be used by analysts to support contract/activity monitoring and commissioners’ requests. The requirements for the minimum data set will follow (note this may change over the course of the contract).

### 7.6 Local Quality Requirements (LQR)

The LQRs have been developed for this service for the first year. These will then be annually reviewed and adjusted.

Examples of ENT specific key performance indicators

* 90% of patients will be seen and treated within a working maximum of 6 weeks. (Two-Week Rule Cancer pathways would be followed for appropriate cases).
* Maximum 10% referrals are directed onwards to secondary care. This includes both those referrals triaged direct to the acute and those patients assessed within the community service and then referred onwards to the Consultant ENT team. Clinical justification will be needed if this figure is exceeded. This figure will be reviewed as necessary.
* Anticipated 80% casemix will be managed in one stop shop. For the remaining 20% of patients the new to follow-up ratio will not exceed 1:1. This means that for the 20% of patients who require a follow up we anticipate one appointment. As microsuction is not included within this ratio it allows the provider more scope for reducing and managing follow ups.
* All onward referrals to secondary care to be sent with minimum data set information including date of receipt of referral at the GPSI service within 5 working days. This is to ensure that the receiving hospital is able to comply with 18 week target requirements.
* Patient’s requiring microsuction will be seen in a nurse led microsuction clinic.
* DNA rates are equal to or less than 10% of the patient group. Robust recall and monitoring of DNAs should be in place.
* Clinical outcomes relating to ENT conditions such as the guidance within NICE and other Clinical PROM as agreed with Commissioners.
* SURE scores for evaluating Shared Decision Making.

|  |
| --- |
| 8.0 Equality, Sustainability (Environmental) and Social Value |

To achieve equality, sustainable with social value the Service will need to ensure that it:

* Provides access to the right care in the right place by the right person;
* Establishes standards for quality of care within an effective and integrated service/network;
* Improves patient care and outcomes from the Service;
* Maximises prevention, either as part of the Service or another closely related service;
* Reduces supply induced demand, by ensuring that need has been demonstrated;
* Uses best available evidence of effectiveness in deciding details of service design and local population need.

### 8.1 Equality

The NHS Horsham and Mid Sussex CCG, NHS Crawley CCG and Coastal West Sussex CCG are mindful of the obligations under the Equality Act 2010 not to discriminate on unjustifiable grounds in the provision of services and public functions. It is also mindful of its obligations as a public sector body to have due regard to the need to eliminate any conduct prohibited by the Act; advance equality of opportunity; and foster good relations between those with protected characteristics and those without. The Service will be required to show at all times that it meets its obligations under the Equality Act, including but not limited to:

* Meeting the provisions of the standard NHS contract relating to equality and diversity issues;
* Collecting appropriate monitoring data;
* Evidence of appropriate Equality Awareness training for all staff; and
* Equality Impact Assessment of service provision

### 8.2 Social Value

The Public Services (Social Value) Act 2012 requires commissioners of public services to consider how their commissioned services might improve the economic, social and environmental wellbeing of the relevant area; and how in conducting the process of procurement, they might act with a view to securing that improvement.

Social value describes the wider social benefits achieved from high quality public services. It aims to generate wider benefits from investment in health services. It promotes the wellbeing, health inclusion and employment of local people and communities. Adopting an approach based on social value principles requires a change to the traditional mind-set of the care system from one which sees communities and people having needs, to one which understands and empowers them as having assets that contribute to our health and wellbeing. Social value benefits could for example include improved community resilience, increased training and education opportunities or reduction in demand for public services.

###

### 8.3 Sustainability

The new Service will be required to show how it will deliver a sustainable service.

The Good Corporate Citizenship is a NHS tool to help the Service on how it can contribute to a sustainable development. . <http://www.sd-commission.org.uk/pages/health.html>

There are 5 principles which need to be taken into account:

* Living within environmental limits;
* Ensuring a strong, healthy and just society;
* Achieving a sustainable economy;
* Using sound science responsibly;
* Promoting good governance.

The Service must:

* Have a Board-approved sustainable development management plan;
* Be signed up to the Good Corporate Citizenship Assessment Model;
* Have in place measure monitors and try to reduce carbon where possible in the organisation;
* Be an organisation which has an awareness of sustainability at every level of the organisation and works to change the behaviour of all employees to improve sustainability;
* Be a Nominated Sustainable Development Champion;
* The new Service will be required to show how it will deliver a sustainable service.

|  |
| --- |
| 9.0 Armed Forces |

In accordance with the requirements of:

* The Armed Forces Act 2011: Annual duty to report progress against the Military Covenant to Parliament including Health;
* Health and Social Care Act 2012;
* NHS Mental Health Strategy 2011.

The Service must meet the spirit of the Community Covenant in working together with Military, to improve the health of veterans, serving personal and their families.

* The Service must ensure that military veterans receive appropriate treatment, ensuring a smooth transition for injured personnel into NHS care as well as providing priority treatment for conditions relating to their service. Veterans at their first outpatient appointment will be scheduled for treatment quicker than other patients of similar clinical priority.
* ‘No disadvantage’ means veterans/serving personnel and family should not lose their place on a hospital waiting list as they move house across the UK. If an individual moves within the UK, previous waiting time will be taken into account, with the expectation that treatment will be within national waiting time standards (i.e. maximum 18 weeks).

A veteran is an individual who has served as a member of the regular services, voluntary reserve and national service.

The Service should ensure the organisations are supportive towards those members of staff who volunteer for reserve duties.

|  |
| --- |
| 10.0 Thresholds |

**10.1.1 Clinical Policies and Individual Funding Requests**

NHS Horsham and Mid Sussex CCG, NHS Crawley CCG and Coastal West Sussex CCG have a commissioning policy with regard to a range of treatments and procedures that are deemed to be low priority for NHS funding. These procedures are classified as low priority due to a number of reasons, such as a low health outcome benefit, lack of clinical evidence, poor value for money etc.

The policy has always been clear that there is not a blanket ban on these procedures. If a referring (or receiving) clinician believes that a patient should be treated as an exceptional/rare case they are able to make an individual request to the CCG’s Individual Funding Request Panel, the details for this can be found on the Horsham and Mid-Sussex, and Crawley CCG’s website.[**http://www.horshamandmidsussexandcrawleyccg.nhs.uk/intranet/resources2015**](http://www.horshamandmidsussexccg.nhs.uk/intranet/resources/?categoryesctl9901866=12421)

Contact details for Coastal West Sussex Individual Funding Request Panel can be found on our intranet pages [**http://www.coastalwestsussexccg.nhs.uk/whos-who?item=910**](http://www.coastalwestsussexccg.nhs.uk/whos-who?item=910)

The Service will ensure that all patients referred onto secondary care meet the criteria for surgery/treatment according to the CCG *‘Commissioning for Clinical Effectiveness’* guidance and the referral guidelines that underpin the service.

|  |
| --- |
| 11.0 Business Continuity |

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR). New arrangements for local health EPRR form some of the changes the Health and Social Care Act 2012 is making to the health system in England.

In March 2013 the core standards which providers must meet were published. For more detail see <http://www.england.nhs.uk/wp-content/uploads/2013/03/eprr-core-standards.pdf>

The Service must have an Accountable Emergency Officer. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

The Service will produce and agree with the Commissioner an appropriate Emergency Preparedness and Business Continuity Plan.

|  |
| --- |
| 12.0 Finance |

TO BE ADDED

|  |
| --- |
| 13.0 Estates |

It is the Service is responsibility to source the premises in accordance with the population needs and precedence to clinics in each of the Communities (Crawley, Horsham, Burgess Hill, Haywards Heath and East Grinstead, Adur, Arun, Chanctonbury, Chichester, Regis, Worthing). Suitable premises for delivering the Service are key hence the service must conform to the following:

* + Ensure the site(s) included within their bid are clinically fit for purpose and most critically, are Care Quality Commission (CQC) accredited (or will become CQC accredited prior to service commencement) for provision of Minor Surgery.
	+ Ensure the site(s) are compliant with relevant Clinical Governance policies and legislation.
	+ Providers should ensure that services are accessible in terms of geographical location and should be accessible to public and private transportation and parking facilities. Sites should also be accessible by patient transportation service vehicles for those patients with identified clinical need for transportation.
	+ Providers should make reasonable adjustments in order that services are accessible e.g. appointments times, length of appointments, information and signage to demonstrate compliance with their Disability & Equality Duty. All premises are required to be DDA (Disabilities Discrimination Act) compliant.

The commissioners seek improved geographical access to services, including:

* Clinic locations that is able to demonstrate their accessibility by both road and public transport for those patients where private transport is not an option.
* All clinic locations should have a surgical treatment room and facilities in line with the national standards for minor surgery.

The following list describes the resource requirements that would be expected as a minimum. This list is not exhaustive and should be used as a guide:

* + Complete access to diagnosis and treatment in convenient geographical locations;
	+ Access to consultation rooms and appropriate facilities for diagnosis and treatment procedures;
	+ Administrative support to ensure that clinics are organised and reported. This will include management and storage of patient records.
	+ The service provider will have a commitment to moving towards an integrated health record for all patients into the service.
	+ Information technology and arrangements for IT support and information Governance.

There must be infection control procedures and protocols including decontamination which should comply with NHS standards.

The Provider will be responsible for ensuring they are registered with the Care Quality Commission to provide the service from their chosen location(s).

|  |
| --- |
| 14.0 Information Technology |

**14.1 Strategic alignment**

The Service’s IM&T strategy should be aligned with national NHS IM&T strategies and the CCG’s IM&T strategy. Key deliverables are:

* Integrated Digital Care Records
* Patient Access to care records

**14.2 Reporting Requirements**

The service must submit data sets that comply with all published NHS information standards. Reports will be required for National requirements but also to support local performance and quality monitoring see section 13 and below:

* National requirements reported centrally via the Health and Social Care Information Centre (HSCIC)
* National requirements reported locally
* Local requirements reported locally

The service should have a Data Quality Improvement Plan to ensure that they achieve the expectations for high quality data described in *Everyone Counts: Planning for Patients 2013/14.*

**14.3 Information Governance**

* The service should manage service user identifiable data in accordance with the law, good clinical practice and/or health and social care practice.
* It is a requirement that the service meets the requirements set out in the Information Governance Toolkit (IGT) at a minimum level 2 performance.
* Where there is a requirement to integrate their IM&T solution to NHS systems and services, the service will need to complete an information governance statement of compliance.
* The service should ensure that any suppliers and sub-contractors with access to service user information and to any NHS systems or services as part of the contract meet the same IG obligations and the provider themselves

The service will have in place a completed NHS Information Governance Statement of Compliance (IGSoC) process, comprising:

* IGSoC signed by the most senior executive in the organisation, and sent from that individuals mailbox (usually the CEO) to igsoc@nhs.net;
* Logical Connection Architecture – a description of the applying organisations network infrastructure;
* Sponsorship letter from the NHS organisation to which you provide services.
* All IGSoC processes will have to be approved via Connecting for Health IGSoC Team. <http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/igsoc>

The service will comply with all relevant national information governance and best practice standards including:

* NHS Security Management – NHS Code of Practice;
* NHS Confidentiality – NHS Code of Practice.

The service will participate in additional Information Governance audits as agreed with the Commissioner.

The service must complete and provide evidence that they have achieved a minimum of level 2 scores for their organisations Information Governance Toolkit <https://nww.igt.hscic.gov.uk/>

**14.4 System Compliance**

The NHS Number must be used to support the sharing of patient information and to help healthcare staff and the service provider match the service user to their health records. The NHS Number should be included on all patient documentation. To help facilitate the use of the NHS Number the provider should use:

* The Patient Demographic Service (PDS)
* The Demographic Batch Service (DBS)
* Interoperability Toolkit Spine Mini Services

To enable reporting via NHS systems the provider will require a unique Organisation Data Services (ODS) code for their organisation.

In order to use NHS IT services the provider must obtain an N3 connection.

The service will be required to register for NHS mail to provide a secure email service for the transmission of service user identifiable data.

When implementing Integrated Digital Care Records systems the provider must ensure that systems built or procured provide Open Application Programming Interfaces (APIs) in line with the NHS Technology Strategy and the IT Interoperability Toolkit.

The Service must cooperate with all National application service providers, national infrastructure service providers that are responsible for, among others:

* Choose and Book(or equivalent system); use of the Directly Bookable Service (DBS) for all patient referrals into secondary care;
* GP systems e.g. SystmOne, EMIS, Vision and others;
* NHS Summary Care Records plus ensure that all patient records are kept in the national compatible format and when available to communicate with the national spine services;
* Electronic Transfer of Prescriptions; use of the electronic prescribing service for supply, administration and recording of medications prescribed and transmission to the Prescription Pricing Division (PPD);
* Patient Demographic Service; use of the PDS to obtain and verify NHS Numbers for patients and ensure their use in all clinical communications;
* NHSMail; use of the NHSMail email service for all email communications concerning patient-identifiable information;
* N3 ; use of the national network for all external system connections to enable communication and facilitate the flow of patient information;
* IEP (Image Exchange Portal); The National Data Sharing Network, web-based application for secure transfer of patient images and reports to secondary care as necessary;
* EPR (Electronic Patient Record).

**14.5 Information Standards**

The service should be aware of and operate in accordance with the requirements of the following:

* Information Standards Board and the Information Standard Notices it issues.
* NHS Data Model and Dictionary Service
* Health and Social Care Information Centre (HSCIC)

**14.6 Informatics Lead**

The service should nominate an Informatics Lead to support the contract and be responsible for meeting the requirements and any new requirements that emerge during the lifetime of the contract.

**14.7 NHS Terminology**

The service must comply with NHS Terminology Service (**NHS TS**), NHS Classifications Service (**NHS CS**) and Healthcare Resource Groupings (**HRG**) including:

* Read Codes and migrate to SNOMED CT (UK Edition) when available;
* NHS Dictionary of Medicines and Devices;
* Office of Population Census and Surveys (OPCS) version 4.3;
* National Intervention Classification Service (NIC);
* International Classification of Disease (ICD) version 10; and
* Healthcare Resource Groupings (HRG) version 4; and
* Information Standards Boards (ISB).

14.8 IG Toolkit

The provider must complete the Department of Health IG Toolkit submission and demonstrate achievement of level 2 or higher.

The service must acknowledge the role of ISB and comply with any mandated changes specified by the ISB during the period of the contract. In addition the provider must comply with ISB0160 (aka DSCN 18/2009 <http://www.isb.nhs.uk/library/standard/162> ). The ISB concerns clinical safety.

|  |
| --- |
| 15.0 Workforce, training and Education |

The Service workforce model must be capable of meeting all the requirements of the service specification and must be flexible enough to deal with fluctuations in demand and capacity without detriment to service delivery.

The commissioner is looking for innovative approaches to workforce provision, which puts clinical safety and quality at the heart of the service with an emphasis on patients being seen by the most clinically appropriate person at the most appropriate time.

The Service will have responsibility for ensuring that suitable training, development, appraisal and mentoring arrangements exist for all clinicians working within the service and that training and supervision is provided to ensure succession planning for future provision of ENT services.

Clear policies on staff accreditation, supervision, CPD, and registration in line with national guidance must be demonstrated and adhered to. Relevant certification of accredited training for the undertaking of any procedures, including surgery, must be provided.

The Service will be required to ensure the required workforce policies, strategies, processes and practices comply with all relevant employment legislation applicable in the UK and also comply with the provisions outlined in:

* + Safer Recruitment – A Guide for NHS Employers (May 2005);
	+ The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) (the Code of Practice); and
	+ NHS Employment Check Standards (updated July 2013).

The Service will ensure that all staff members have the training and development they require to deliver the services in a way such that patients receive compassionate, efficient and empathetic care and is inclusive of training in Shared Decision Making.

**15.1.1 Administrative staff** must be adequately trained in both patient confidentiality and ENT terms and policies, and must be provided with appropriate word processing and data collection facilities to allow for proper clinical audit and to support NHS Horsham and Mid Sussex CCG, Crawley CCG and NHS Coastal West Sussex CCG information requirements.

**15.1.2 Nursing staff** within the service should be registered with Nursing and Midwifery Council and hold recognised qualifications for any treatments they undertake. The nurse led microsuction clinic should ensure competencies in microsuction are undertaken and appropriate peer supervision/Consultant ENT surgeon/GPSI in ENT supervision. Maintain a professional development logbook, recording, practical supervision received, course attended and other related further education. Also be in receipt of feedback on performance.

**15.1.3 GPSI in ENT** as part of this service, staff will require familiarity with the local healthcare environment, systems and policies in order to work effectively at the interface with key services. They should also be on the ENT specialist register at the General Medical Council. The GPSI ENT team must demonstrate experience and training in ENT conditions.

The Provider will be responsible for ensuring that GPSIs have been assessed as competent, hold current professional registration and indemnity insurance and who also meet the following criteria:

* Undertake annual peer supervision;
* Maintain a professional development logbook, recording, practical supervision received, courses attended

and other related further education;

* Be in receipt of feedback on performance;
* GPSIs will be supported and mentored by a named ENT Consultant.

**15.2 Clinical Networks**

The ENT providers will work with other ENT healthcare providers to join or establish a clinical network to share clinical outcomes and facilitate clinical exchange of information.

**15.3 Education and training Requirements**

The Service will establish links to and work with Health Education England Kent, Surrey, Sussex (HEEKSS) in providing educational opportunities for all professionals aligned to ENT as a speciality.

In accordance with best practice the Service will provide opportunities and placements for existing and new learners (including junior doctors and surgical trainees) in training to gain work based experience within the Service, with appropriate supervision by accredited trainers within the Service to the standards set with the relevant training and governing bodies. The Service will require that staff members adhere to and demonstrate the NHS Values to ensure that students/trainees are exposed to effective role models in practice.

The Service will make a commitment to training and development for their own staff, which will include protected time for high quality training and ensuring sufficient staff members are available to teach and assess students in practice.

The Service as an employer has the responsibility to fund and organise statutory and mandatory training as well as ensuring Continued Professional Development (CPD).

Time is required to ensure supervision and support needs are provided for clinical staff and to ensure that skills and competencies are developed and maintained. There should be opportunities for debriefing and learning when situations arise.

The Service will support and encourage GP and other primary care staff through education to ensure that there is a good understanding in ENT conditions particularly with respect to early diagnosis and referral.

The Service must demonstrate that staff delivering the service are fully indemnified to provide the service and shall maintain in force at its own cost appropriate indemnity arrangements as set out in General Conditions Clause GC11 Liability and Indemnity

|  |
| --- |
| 16.0 Research, Audit and Development |

The Service must also develop a culture of training and research to ensure that cutting edge approaches to ENT management are thoroughly investigated and implemented where appropriate and in agreement with the Commissioners.

The commissioners will also expect the Service to demonstrate that they will use an accredited evidence base when designing and delivering services. In addition we encourage providers to seek ways of extending that evidence base through supporting and collaborating in evaluative research. We expect bidders to demonstrate how they will facilitate research and outline areas where they would hope to generate new evidence.

The Service must also make adequate provision, details of which must be agreed with the commissioner, to ensure the service can take part in suitable research programmes and clinical trials, relevant to the furtherance of good practice and innovation in ENT.

|  |
| --- |
| Appendix 1 |

|  |
| --- |
| Appendix 2 |

|  |
| --- |
| Appendix 3 |

|  |
| --- |
| Appendix 4 |