
Leg Ulcer and Wound Healing
Service Specification

DRAFT

Service Specification No.	
Service	Venous Leg Ulcer & Wound Management
Commissioner Lead	Horsham and Mid Sussex and Crawley Clinical Commissioning Groups
Period	
Date of Review	

1. Population Needs

1.1 National/ local context and evidence base

References/Supporting Information:

- A. BMJ - http://clinicalevidence.bmj.com/cweb/conditions/wnd/1902/1902_background.jsp
- B. Leg Club - www.legclub.org
- C. Leg Ulcer Forum - www.legulcerforum.org
- D. RCN Guidelines - <http://www.rcn.org.uk/development/practice/clinicalguidelines>
- E. Tissue Viability Society - <http://www.tvs.org.uk/>
- F. NHS Choices - <http://www.nhs.uk/conditions/leg-ulcer-venous/Pages/Introduction.aspx>
- G. Map of Medicine - http://eng.mapofmedicine.com/evidence/map/venous_leg_ulcers1.html
- H. SIGN - <http://www.sign.ac.uk/guidelines/fulltext/120/contents.html>
- I. European Wound Management Association - www.ewma.org

The impact of leg ulcers on adults can be great both at a personal and a societal level leading to social isolation, depression, loss of independence and employment challenges. Most people with leg ulcers experience pain, and this can be debilitating, leading to a loss of mobility, sleeplessness and social isolation. The impact on quality of life is inestimable.

There are usually between 70,000 and 190,000 people suffering from venous leg ulcers at any one time, and over half of these people have had their ulcer for over a year. Treatment of this major health problem results in a considerable cost to the NHS.

In the United Kingdom it is estimated that 1% of the population will suffer from leg ulceration during their life. Approximately 60% to 80% of leg ulcers will have a venous component and the remaining will have arterial or mixed arterial and venous disease as well as prevalence increasing with age¹. Chronic venous leg ulceration has an estimated prevalence of between 0.1% and 0.3% in the United Kingdom.

The ageing population means that demand for leg ulcer assessment, treatment and healing services is set to rise substantially over the coming years.

Venous ulcers arise from venous valve incompetence and calf muscle pump insufficiency which leads to venous stasis and hypertension. This results in microcirculatory changes and localised tissue ischaemic damage. The natural history of the disease is of a continuous cycle of healing and breakdown over decades and chronic venous leg ulcers are associated with considerable morbidity and impaired quality of life

There is evidence of wide variation in the assessment and management of leg ulcers including assessment skills² with significant potential to improve wound healing rates and reduce reoccurrence. A review of studies addressing the effectiveness of training found that a large number of community nurses perform bandaging inadequately. In two of the studies, techniques improved following appropriate training. This improvement was sustained at 2-4 weeks following training, but diminished to near baseline levels at 6-10 weeks³.

Healing rates in the community, where 80% of patients are treated, are low compared to rates by specialist services/clinics⁴. The improvement in care and outcomes observed in specialist clinics may in part be due to the more stringent delivery of evidence-based recommendations. A study involving specially trained nurses following an evidence based protocol found no significant difference in outcomes for patients receiving treatment at home when compared to clinic treatment and concluded that organisation of care, and not the setting where care is delivered, is the factor which most influences healing rates⁵.

¹ <http://www.sign.ac.uk/guidelines/fulltext/120/section1.html>

² http://www.rcn.org.uk/development/practice/clinicalguidelines/venous_leg_ulcers

³ <http://www.sign.ac.uk/guidelines/fulltext/120/section1.html>

⁴ <http://www.sign.ac.uk/guidelines/fulltext/120/section1.html>

⁵ <http://www.sign.ac.uk/guidelines/fulltext/120/section6.html>

2. Scope

2.1 Aims and Objectives of service

The aim of the service is to improve the quality of life for people with or at risk of recurrence of leg ulcers through the delivery of clinically effective care and advice and reduce the risk of recurrence.

The Leg Ulcer management and healing service will include the assessment, treatment and follow up for patients with Leg Ulcers of venous, arterial and mixed aetiology.

The service is aimed at adults who have been referred with a current leg ulcer for assessment, treatment and advice including after care to minimise recurrence, as long as they meet the referral criteria and do not have contra-indications⁶

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The service will also see and treat patients with post-surgical wounds from Horsham and Mid Sussex practices that have not healed after four weeks.

The management plan may include onward referral to specialist secondary care services where deemed appropriate.

In addition, treatment of complex wounds will be managed within the service until such time as sufficient healing has been achieved and the person can be discharged to the care of their GP practice.

The service is intended to drive improvements in the way in which leg ulcer services deliver care to patients. It should foster continued quality improvement and will expect providers to deliver clear and formal accountability processes and structures to ensure a safe, effective and integrated continuity of clinical care for all patients.

The purpose of the leg ulcer service is to:

- Secure the best possible outcomes for patients and their carers
- Deliver a timely and personalised wound management and healing service in a safe environment, with a maximum wait time of 10 working days for initial assessment and start of treatment for appropriate referrals and flexibility within the service to provide appointments to support more urgent demand

⁶ <http://www.sign.ac.uk/guidelines/fulltext/120/section3.html>

- Ensure onward referral in a timely manner where required
- Prevent unnecessary referrals and admissions to specialist services
- Improve local symptoms such as pain, exudate and odour and healing rate through the use of appropriate treatment in accordance with best practice, published guidance and clinical evidence and reducing unnecessary or inappropriate use of dressings and wound care products
- Promote the use of individualised care management plans for all patients with discharge communication to patients, carers and healthcare professionals that promotes long term leg care and reduces the risk of recurrence
- Provide appropriate patient education so that patients and carers may make informed choices and fully participate in their care and improve concordance/compliance
- Reduce inequalities and improve access, enabling those with physical, sensory or learning disabilities and those who do not speak or read English to have equal access to information and leg ulcer wound healing services through appropriate information leaflets
- Ensure care is provided by appropriately trained and experienced clinicians who are able to demonstrate high rates of wound healing through appropriate and skilled care and advice
- Encourage the active identification and management of people with leg ulcers and improve awareness of the community service through provision of education and training to other health and social care professionals

2.2 Expected outcomes of the service

The Provider is to deliver a high quality service to patients comprising safe clinical practice, clinical effectiveness and positive patient experience. The service outcomes will be dependent and derived from the local objectives of the service, but in all cases the requirement to collect and analyse data to effectively manage the service must be considered.

Key Service Outcomes are:

- Healing rates based on the number of patients and the length of time they take to heal

- To heal a minimum of 90% of leg-ulcers care pathway 1 within a 12 week period⁷.
- To heal a minimum of 70% of leg- ulcers care pathway 2 within an 18 week period.
- To achieve access and appointment targets
- For 100% of initial assessments - Patient to be contacted within 3 working days and offered an appointment within 10 working days of the referral being received.

Other Outcomes / Measures / Reporting Requirements include:

The % of referrals received who are designated Care Pathway 1 & 2 Patient satisfaction/complaints

- Assessment of concordance rate at 4 weeks
- Others to be determined by and agreed with local commissioners. These will include (but not limited to):
 - Rates of recurrence
 - Infection rates
 - Onward referral to secondary care
 - Total number of referrals
 - The number of additional cycles of care by patient on Care Pathway 2
 - Patient reported outcomes measures (PROMs)

2.3 Service description/Care Pathway

2.3.1 Service overview

The service will deliver a common approach for all leg ulcers within the first 4 weeks of care. . Subsequent decision points will facilitate appropriate management via the defined care pathways (see definitions and inclusions below).

⁷ It is suggested that an audit of healing rate is included for 12 weeks to inform further development of this service specification and service outcomes (SIGN)

The service will accept all adult patients referred by an Healthcare Professional where a fully completed referral form has been received. The service is offered to patients with:

- an open lesion to a lower limb who have been assessed by the service to have an ABPI between 0.8 and 1.3 and / or
- who have had a venous leg ulcer which is now healed but are at risk of recurrence for advice⁸

Those patients who have been assessed based on clinical signs and symptoms as having a leg ulcer will be included for care management with compression therapy as appropriate to the patient's clinical needs

The Service will consist of a nurse led model, with assessment and investigation where appropriate, thereby reducing inappropriate/unnecessary referral to secondary care and will include:

- a. Referral triage and face to face specialist assessment (including Doppler testing)
- b. Development of a mutually agreed appropriate management and treatment plan that is co-owned with the patient and carer to heal the wound and improve quality of life
- c. An initial common 4 week pathway for all leg ulcers to assess and treat patients in line with the management plan. Specialist reassessment at 4 weeks against the wound healing curve will further inform the management plan and directing of the patient onto the most appropriate care pathway (Simple-Care Pathway 1 or Complex-care Pathway 2)
- d. Pathway 1 (simple) comprises an eight week pathway irrespective of the number of visits. The tariff will reflect the anticipated average number of visits for this patient cohort Pathway 2 (complex) comprises a 14 week pathway irrespective of the number of visits. The tariff will reflect the average number of visits for this patient cohort.

The commissioners are not anticipating funding repeat cycles of care for Care Pathway 1 but are intending to incentivise delivery of the outcomes within the pathway price for the initial 4 weeks and Care Pathway 1.

⁸ This would form part of the assessment process within the proposed care pathway

For patients on care pathway 2 in the event that the ulcer is not healed at the end of the first treatment cycle providers must contact the commissioner to request an extension and will provide a management plan with the expected outcome.

- e. Following discharge patients will have a review at four weeks.
- f. Where patients on pathway 2 who are unlikely to heal and/or at risk of recurrence the provider may apply to the commissioner to initiate a maintenance pathway (see Appendix 8).
- g. Information on and signposting to any relevant community/social support services, including the promotion of self management
- h. Communication to referring clinician and patients own GP after first consultation, 4 week assessment and on discharge.

The service will be provided by appropriately trained and experienced clinical practitioners (for example both General Practitioners and Nurses) who are able to meet patients' needs and offer the services in suitable premises as defined by the requirements of the NHS contract and Care Quality Commission (CQC) registration for such regulated services.

The service provider will be expected to provide management information consisting of reports related to Key Performance Indicators and routine reporting requirements as defined through a minimum data set and locally defined management information requirements. Information requirements will consist of a customised spreadsheet which will be shared with accredited providers. This will consist of (but is not limited to):

- Patients identification number (but not patient identifiable information)
- Number of referrals per month (number of inappropriate/appropriate referral)
- Total number of assessments completed
- Number of patients assessed not found to meet referral criteria (assessment only)
- Total number of initial 4 week assessment pathways completed
- Total number allocated to simple pathway
- Total number of patients allocated to complex pathway

- Of patient allocated to complex pathway the total number of patients on an extended treatment cycle and rationale
- Of patients on an extended treatment cycle a breakdown by numbers on the first and any subsequent treatment cycles
- Number of patients allocated to the maintenance pathway
- Performance against agreed metrics / Key Performance Indicators (KPIs)

This Care Pathway has been developed with the intention of deploying and utilising evidence based and validated tools such as the Wound Healing Curve.

Patients will be provided with wound management and care in accordance with two Care Pathways based on the wound healing rates demonstrated by services offering excellence in clinical practice¹⁰

- **Care Pathway One - Leg Ulcers without complication** – wound expected to heal within 12 weeks.
- **Care Pathway Two - Leg Ulcers with complication** – wound expected to heal within 18 weeks. Complications known to reduce wound healing rates and increase the duration for wound healing include:
 - Ulcers with some degree of Lymphoedema in the limb
 - Larger ulcers greater than 10cm in any dimension or greater than 100cm²
 - Ulcers already present for more than 1 year at point of referral
 - Not healed by 20 – 40% within 4 weeks
 - Non-concordance

2.3.2 Interdependencies with other services

The Leg Ulcer service should be seen as part of wider integrated adult health and social care services working in partnership with GPs, Primary/Community Health Care teams, specialist services, local authorities, the voluntary & community sector and independent providers.

¹⁰ <http://www.sign.ac.uk/guidelines/fulltext/120/section9.html>

The Provider must demonstrate how it will work with these other organisations to support patients to successfully manage the leg ulcer, minimise recurrence and promote independent living.

Providers shall be required to link seamlessly with all specialist and primary care services. It is the responsibility of the provider to ensure that all appropriate details are communicated to the necessary recipients with notes made in the patient's records. Patient's clinical progress and management and treatment plan will be reported to the GP by the provider within a maximum of 5 working days of discharge. Providers will be responsible for ensuring the accuracy of this information and medication notifications.

The provider should work using an integrated approach with other agencies caring for people with leg ulcers¹¹. Professionals providing care at different levels can be employed by different bodies but if services are to be integrated, in line with clinical governance principles, they should all:

- work to best practice evidence based policies, procedures, guidelines and targets
- use locally agreed evidence based policies, procedures and guidelines where appropriate
- undertake group audit and review

The provider should ensure that staff are familiar with the wider healthcare community and are able to make referrals to other services, including specialist services, as and when required. Partners may include:

- Commissioned Community Services (including out of hospital services, e.g. community dermatology)
- Podiatrists
- Psychologists
- Acute Trusts, in particular vascular teams, dermatologists and diagnostic services
- Social services
- Patient Forums

¹¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005851

- All GP Practices
- Health and Informatics Service
- Health & Wellbeing Hubs

2.4 Service Model

2.4.1 Referral to the service

Suitable local referral guidelines and thresholds for referring into the service will be developed with all accredited providers in conjunction with commissioners to facilitate and support triage to the most appropriate assessment and treatment pathway. Referrals not meeting these agreed thresholds will be returned to the referrer by the provider for the missing information.

Referrers will have two options when considering referring a patient.

Option 1 – a patient can be referred into the service for an assessment (including Doppler or duplex scan) and then discharged back to the referrer with a suggested management plan.

Option 2 – a patient who has followed the 4 week assessment pathway and requires further treatment will be streamed to the appropriate package of care (either simple or complex).

In either case, there is an associated tariff, details of which to follow.

The service provider will contact the patient within 3 working days of receipt of referral and offer an appointment for an assessment within 10 working days of the receipt of referral. This may be in a clinical or community setting. Patients who are deemed as an urgent referral will be contacted and seen within 3 working days. A dedicated telephone line must be made available for patients to call to make appropriate arrangements to attend clinics and also to inform the service if they need to cancel and rearrange an appointment. This service should have an answer phone facility for patients to leave messages and these should be responded to within 1 working day.

The commissioners anticipate that HCPs will be able to refer into the service using either secure fax or email or via choose & book.

Some patients will require the use of patient transport to accommodate their appointment with the service. Patients should be informed of this option and are responsible for organising their own transport if they meet the CCG eligibility criteria.

Consideration should be given to transport turnaround times for those patients who require it to facilitate earlier or later appointments in accordance with the operating times of clinic locations. For example, where a patient has an appointment allocated for an afternoon clinic their appointment should be as early as possible to ensure that they can be collected within 2 hours following their appointment.

2.4.2. Assessment

Patients should be offered an initial assessment appointment which will cover any history of prior deep venous thrombosis or previous treatment for varicose veins. Management of a patient with chronic leg ulcer will often be influenced by the patient's comorbidity. Factors such as obesity, malnutrition, intravenous drug use and co-existing medical conditions will affect both prognosis and suitability for invasive venous surgery. Personnel should take a full holistic assessment and complete history which would encompass the points below as well as a full clinical assessment:

- Severity of patient reported symptoms of their leg ulcer (as required via monthly management information)
- Patient reported quality of life using a validated Health Related Quality of Life (HRQoL) tool e.g. Centre for World Indigenous Studies (CWIS) (as required via monthly management information)
- The patient's mobility should be considered as well as the availability of help at home, as many patients find graduated compression hosiery difficult to put on
- Leg ulcers are frequently painful, particularly if they are associated with cellulitis or deep infection and strong analgesics (for both Nociceptive and Neuropathic) are likely to be required.
- A detailed description of the ulcer (including size, appearance and position), will be recorded in the patient's notes to include a photograph as a minimum and tracing of the margins and measuring the two maximum perpendicular axes. The depth should be described in terms of the tissue involved in the ulcer base.
- The leg should be assessed for signs of venous or arterial disease, in particular, varicose veins, venous dermatitis, haemosiderin deposition, lipodermatosclerosis and Atrophie Blanche. A venous duplex scan may aid assessment of the leg and providers should ensure that access to the diagnostic pathway with maximum referral to report times of 15 working days are in place.

- Oedema should be assessed and non-venous causes of unilateral and bilateral oedema ruled out.
- Joint mobility particularly that of the ankle should be carefully recorded.
- Measurement of ankle brachial pressure index by a hand held Doppler device (or another assessment of arterial status) should be performed by an appropriately trained practitioner.
- Bacteriological swabs should only be taken where there is clinical evidence of infection.
- Leg ulcer patients with dermatitis/eczema should be considered for patch-testing using a leg ulcer series.
- At the initial assessment and where appropriate, the patient's leg will be bathed, moisturiser applied if necessary, the wound re-dressed and appropriate compression applied from the provider's stores.

If the patient **does** meet the required referral criteria, the provider will make and record an individual treatment plan for each patient. The patient will start a four week period of treatment.

For complex patients there must be the opportunity for the management plan to be informed by access to a Tissue Viability Specialist Nurse. This could be done by telephone.

- It would be prudent, but not mandatory, to carry out a risk assessment (a history) of the patient's infectious status in the initial assessment (infections for example MRSA, Clostridium difficile need to be documented and communicated: should an infection occur this may influence the prescriber's decision when selecting antimicrobials prior to culture results being available).

As part of the initial assessment the patient will be assessed for the likely care pathway and duration of healing.

Criteria for acceptance

- All adult patients (18 and over) registered with a practice in the Crawley, Horsham and Mid Sussex CCG area

- Patients with an ulcer of either the upper or lower limb (excluding the foot¹²) due to venous or arterial insufficiency or other pathologies
- Patients with non-healing post-surgical wounds (Horsham and Mid Sussex patients only). The wound should be non-healing for a minimum of 4 weeks post-surgery

Criteria for inclusion in Care Pathway 1 – Simple Leg Ulcers

- Leg ulcer(s) with ABPI greater than 0.8 and less than 1.3¹³
- Wound area is less than 100 cm²
- Ulcers will not have been present for more than 1 year

Criteria for inclusion in Care Pathway 2 – Complex Leg Ulcers

- Leg ulcer with ABPI greater than 0.8 and less than 1.3
- Wound has been present for more than 1 year on first presentation to the service
- Patient has Lymphovenous disease (in some circumstances this comorbidity will not necessarily result in a classification of complex and will be agreed with providers/local health economy)
- Wound area is greater than 100 cm²
- Patient has history of non-concordance
- Wound has failed to reduce in size by 20 - 40% despite best practice at 4 weeks
- Where a leg ulcer with ABPI >1.3 is present then it should be first determined the cause of the ulcer. Assuming no comorbidities and the ulcer is venous in nature then the patient can be treated.
- Patient has an arterial ulcer or ulcer of mixed aetiology, an open lesion to an upper or lower limb and/or chronic oedema of the lower limb, and complex

¹² Foot wounds and ulcers that have not healed after 4 weeks of treatment in primary care should be referred to a podiatrist

¹³ Patients with an ABPI of <0.8 should be referred for a specialist vascular assessment. SIGN 2010

wounds, such as non-healing surgical wounds of > 4 weeks duration (Horsham and Mid Sussex only) and pilonidal sinus.

The nature of the likely treatment and care package will be explained to the patient and their informed consent will be obtained. Information will also be given to the patient on good self-care so as to promote healing.

Exclusion criteria

Where a referral is deemed to be inappropriate and the patient is to be referred back to the care of the GP a full report must be sent including results of all the general physical and wound assessment together with a suggested future treatment plan.

Patients who have the following features should be referred to the appropriate specialist or service at an early stage of management:

- Lymphoedema, wounds on the foot, pressure ulcers, cancerous wounds and non- healing amputation wounds
- Patients with suspicion of malignancy should be referred to the appropriate provider under the two week rule
- Patients with rheumatoid arthritis/vasculitis should be referred into secondary care based rheumatology services
- Patients with suspected contact dermatitis or dermatitis resistant to topical steroids should be referred into the Community based Dermatology Service for assessment and treatment

In all cases the patient should continue to receive conservative treatment until diagnosis.

(Providers should note that services will be subject to Audit within the scope of the Contract for NHS services).

Patients with diabetes mellitus may still be managed within the service where a leg ulcer is evident (excluding the foot) and treatable and ABPI <1.3 but the patients GP must be consulted with and kept fully informed at each stage of the treatment process. Any negative changes in the patient's condition should be notified to the appropriate healthcare professional (which may include secondary care) at the earliest opportunity.

2.4.3 Treatment until the ulcer is healed

Further visits as necessary will be made by the patient until the ulcer is healed. At each visit, the compression system and dressings will be removed, the leg bathed in

normal tap water and dried, moisturiser applied as necessary and the leg redressed and compression applied as appropriate and in accordance with the care plan and in accordance with published clinical evidence and best practice.

The frequency of the visits will be decided by the provider, with reference to the wishes of the patient, their carer and clinical need.

During the treatment sessions, the following should be considered, provided and discussed with the patient and their carer:

- Compression therapy systems to reduce venous hypertension will be applied. Dressings, applications, and compression system should be chosen as far as possible to avoid the most frequent sensitisers, and care should be taken to avoid further exposure to allergens identified by patch-testing in individual patients.
- Complex patients would benefit from joint consultation which should be arranged with multidisciplinary input across secondary, tertiary and community care, where appropriate.
- Patient's dignity should be maintained at all times

Patients and their carers will also be encouraged to take an active part in their own care wherever possible, and will be given all necessary education and information to aid this. Information will be given to promote and encourage patient concordance with treatment and future leg management (see the checklist for provision of information in Appendix 6). Patient concordance with treatment is likely to improve if they are properly informed about the disease and its management

After four weeks of treatment and following review, a decision will be finalised as to whether the patient can be discharged back to their GP with a management plan or are streamed to either the simple or complex pathway of care. There should be the facility for this decision to be informed with the input of a Tissue Viability Specialist Nurse where required. The TVN will verify the decision and the anticipated outcome and this must be recorded in the notes. It may also be prudent to obtain a duplex scan at this point if the leg ulcer is not healing at the expected rate. If the pathway changes from the decision recorded at the initial assessment the provider must inform the referrer (and the patient's GP if different) giving a detailed explanation of the care plan and decision on why the patient has been categorised as simple or complex. The provider will then continue with the treatment plan until the wound is healed.

The mainstay of treatment of a leg ulcer involves compression therapy to reduce hypertension. Dressings are required to prevent the compression system from

adhering to the wound and treatment of the skin surrounding the ulcer. The peri-ulcer skin should be treated routinely with a bland emollient, and if appropriate ulcer margins should be coated with a barrier preparation to prevent maceration of surrounding skin. Details of appropriate dressings for use can be found within the current Dressings and Wound Care formulary available at

<http://www.chmsformulary.nhs.uk/chaptersSub.asp?FormularySectionID=26>

- At initiation of compression, the patient will be assessed for skin complications within 24-48 hours. When considering the type of compression to use, the provider will take into account:
 - Patient preference, lifestyle and likely concordance
 - Required frequency of application
 - Size and shape of leg

2.4.4 Discharge and follow up once the ulcer is healed and preventing ulcer recurrence

Once the ulcer has healed, a plan will be made with the patient and their carer on the self-care required to prevent recurrence. It will be documented in the patient's notes and shared with the GP practice.

Below-knee graduated compression hosiery is recommended to prevent recurrence of leg ulcer in some patients where leg ulcer healing has been achieved. Patients should be offered the strongest compression which they can tolerate to prevent ulcer recurrence. Patients should be informed that it is likely that compression will be required indefinitely. Prescriptions should specify the class and generic type of stocking and be of a quantity to allow for frequent washing. The GP must be informed of the details of the prescription given to the patient to inform repeat prescribing. Criteria will be agreed during the implementation phase.

If a patient finds a stocking uncomfortable, changing the brand of stocking within the same class may improve compliance. Made to measure hosiery should be offered when fitting is otherwise difficult along with a devices which may be useful for patients who find the application of stockings difficult.

At the final appointment, an assessment will be made of concordance with the self-care plan and a final report provided to the referrer (and the patient's GP if different) within 5 working days. The report should include all relevant information, including the

intention to make a further final assessment after four weeks following healing and ongoing use of hosiery.

On discharge the provider must ensure that both patient and GP are aware of the process for entry back into the service which may include self referral.

2.4.5 Aftercare and further review

There should be a follow up telephone consultation within 4 weeks of discharge or a face to face review where assessment and prescription of new hosiery is required. Clinicians are fully supportive of the providers supporting patients ongoing healing in the form of patient education which may consist of healthy leg clubs or similar. The aim of this is to minimise the risk of recurrence.

2.4.5.1 Maintenance pathway

As per the KPI, over 70% of patients on Care Pathway 2 will be healed on conclusion of the pathway. However for the remaining 30% of patients the commissioners anticipate that a further extension to the pathway will be required. This will require a request to the commissioners to extend the pathway together with a management plan that will include the anticipated outcome.

In rare circumstances complex patients may require acceptance onto the maintenance pathway (see Appendix 8). This will need to be agreed with the commissioner. The commissioners need to be made aware of the clinical need of a maintenance pathway and give agreement prior to commencing it.

2.5 Care pathway

The care pathway can be viewed at appendix 4.

2.6 Population covered

2.6.1 All eligible registered patients referred from a locally registered general practitioner within the Crawley, Horsham and Mid Sussex areas of the North of West Sussex.

2.6.2 Patient compliance and Do Not Attends (DNAs)

When a patient is non-concordant or DNAs twice they are referred back to the referrer for their care. The provider will work in partnership with the patient to understand the reasons for non-concordance, including consideration and minimising pain, and

discomfort. Information and advice should be provided to reinforce understanding on why compression is necessary and is worthwhile and prevents recurrence¹⁴

2.7 Location of service delivery

The service must be provided in a geographically convenient, easily accessible location. This may be in a practice or community setting. Details of patient demographics and other useful information can be found at appendix 7.

2.8 Housebound patients

It is not expected that the provider will routinely provide care for patients who are housebound. However there is an expectation that the provider will provide advice and guidance to the healthcare professionals (e.g. District Nurses) who are commissioned to manage patients in their normal place of residence (which may include a nursing/care home).

The exact nature of this advice and guidance may include (but will not be limited to):

- Telephone advice to HCPs who are having difficulties with concordance with a patient and this is having an adverse effect on their healing
- Where specialist advice (e.g. tissue viability) is necessary to treat a patient
- Education for HCPs to assist with improving healing rates and patient outcomes
- Joint visits to the patient at home with an HCP to assess the patients care needs and provide advice on the treatment options available

3. Applicable Service Requirements

3.1 Key Requirements

Any and all treatments undertaken by the providers as part of the service must be robust, evidence based, clinically effective treatments and the provider must be qualified and registered to provide these treatments with the appropriate regulatory or professional body.

The provider is required to meet, as a minimum, requirements set out in the NHS Contract and the Care Quality Commission¹⁵.

¹⁴ DNA remains a provider risk

The provider must ensure systems and processes are in place to ensure continuity of care based on clinician, information and treatment.

The service must have a clinical risk management system in place.

The service should be able to demonstrate that they have in place and operate effective management systems for Infection Prevention and Control.

The provider must ensure that a senior lead clinician with a managerial responsibility takes the lead for the day to day running of the service.

The provider must supply information to patients in a variety of ways. For example, advice leaflets, DVDs, visual tools, and a website. A facilitated group approach and expert patient involvement where appropriate may also be a useful tool for concordance. The provider needs to develop a 'Healthy leg network' for patients and their carers which will initially be provider led but long term should be led by the patients. This can include face to face meetings, virtual meetings, newsletters etc. In addition support for carers should be considered. Other formats, such as Braille, large print, audio cassette or CD, must be made available if the need has been identified and information should be age and language appropriate¹⁶.

The provider must be responsive to people with learning disabilities, mental health problems and those from ethnic minority groups. The provider must ensure all staff undertakes mental capacity training, equality and diversity training and conflict resolution training¹⁷.

The provider must ensure that the best interests of people are maintained through constant evaluation with a system for continuous improvement.

The provider must raise awareness of the service amongst other health care professionals to minimise referral delays.

The provider must fulfil patient and public expectations of:

¹⁵ Essential Standards for Quality and Safety <http://www.cqc.org.uk>

[/sites/default/files/media/documents/essential_standards_of_quality_and_safety_march_2010_final_0.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/essential_standards_of_quality_and_safety_march_2010_final_0.pdf)

¹⁶ Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, cultural or language barriers including British Sign Language (BSL). The Provider should make adequate and reasonable provision for interpreters, carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.

¹⁷ http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/essential_guide_guidance.pdf

- Empathetic and compassionate care provision
- Staff who have specialist skills, knowledge and experience and who undergo regular training
- Holistic approach, understanding and supporting the impacts of the condition on the patients and carers quality of life
- Encouraging self-care and empowering service users to be proactive and involved in the management of their condition

The Provider must also ensure that the following levels of supervision are provided to the clinical staff team:

- Management supervision
- Clinical supervision
- Safeguarding Supervision

3.2 Applicable local requirements

3.2.1 Referral and Response Times

The service must provide triage and assessment daily Monday to Friday and provide an initial assessment for all new patients referred and accepted into the service.

Upon receipt of a referral, the service provider will contact the patient within 3 days of receipt of referral and offer an appointment for an assessment within 10 working days of the date of referral. If the referral is urgent then the patient should be contacted for an assessment within 3 working days.

3.2.2 Prescribing

It is expected that providers will maintain stocks of all appropriate materials (including dressings) for the ongoing provision of the service. It may be necessary, by exception, to request a patient's GP to prescribe medication relating to the treatment (e.g. for pain relief). The provider will be expected to take all necessary steps to ensure that this process is fully communicated to the GP and the patient and that delays in prescribing are kept to a minimum.

All providers are expected to abide by the locally agreed prescribing formulary for Venous Leg Ulcer care which can be found at

<http://www.chmsformulary.nhs.uk/chaptersSub.asp?FormularySectionID=26> wherever possible. Providers may use products outside of the formulary where these are clinically evidence based and no additional cost will be incurred by the patient or the patient's practice. Once a patient is discharged back to their GP's care any prescribing must abide by the published formulary.

Providers may not accept sponsorship from pharmaceutical companies without prior authorisation from the commissioners for any part of the provision of this service.

4. Other

4.1 Workforce

The service must:

- Provide fully skilled and trained, appropriately qualified and experienced personnel and provide a competency based training package to ensure staff have the required knowledge and skills to deliver safe and effective practice. In order to work unsupervised, staff must be able to demonstrate that they are knowledgeable and competent in key areas / skills indicated below:
 - Fully understand the implications/impact of leg ulcers on patients' health and wellbeing.
 - Patient history taking and clinical assessment
 - Assessment of arterial supply (by which ever method is used in local practice e.g. Doppler or ABILITY)
 - Wound assessment
 - Appropriate dressing selection and application to achieve wound healing
 - Measurement of limbs
 - Application of compression system(s) as used locally
 - Documentation and effective communication
 - Prescribing where required
- Appoint a named senior lead clinician with a managerial responsibility who must be a registered healthcare professional with 5 years' experience.
- Staff must have access to advice and guidance from appropriately qualified Tissue Viability Specialist Nurses to aid them in the treatment of patients. Non-

medical prescribers must also be available to assist with the treatment of patients as necessary.

- Non-medical prescribers working within the service must meet Post Registration Education and Practice (PREP) standard from the National Medical Council (NMC) and adhere to the standard operating procedures for prescribing dressings and wound care products
- Identify a governance lead, with responsibility for National Patient Safety Agency (NPSA) alerts. Risk management must include the reporting of all clinical incidents to the NPSA anonymously and have a broadcasting system to all health professionals within the service regarding NPSA, MDA and medication alerts. The provider must demonstrate the evidence on how this mechanism functions. A governance framework should stipulate the operational management, resources and identify staff numbers, title and WTE. Information governance toolkit must demonstrate level 2 and above.
- Support continuing professional development for all staff with clinical leadership and supervision, all clinicians where appropriate to attend regular meetings including MDT for peer support. Clinicians must be encouraged to engage with any relevant networks across the health economy and should be multi professional.
- The provider must ensure the safe delivery of clinical services providing a leadership structure and governance that is fit for purpose. The provider will be expected to promote a culture of learning within its organisation ensuring the following are provided:
 - Clinical leadership;
 - Integrated governance;
 - Clinical safety and medical emergencies;
 - Incident reporting.
 - Management and reporting of Serious Incidents requiring Investigation as per NPSA guidelines (2010),

The Provider is responsible for ensuring the safety of patients whilst on their premises and/or under the care of their staff and departments and/or throughout the discharge process. The Commissioner expects that they have robust risk management systems in place including incident reporting and learning, risk assessment and a risk register. The commissioner requires providers to:

Allow the commissioner to audit provider risk management systems, including a review of policies, procedures and meeting with accountable individuals. To be undertaken only if failing in risk management systems red flagged by major event such as failing to achieve present NHSLA standard.

Notify any appropriate regulatory bodies (NPSA, RIDDOR, HPA, CQC, Police, SHOT, Adult Social Care (SVAs), Children's Services (SVCs)) of any incident requiring reporting. Any exceptions should be reported via the Quality review meeting.

Comply with the NPSA Being Open Framework. If an incident has resulted in harm being caused to a patient the provider's Being Open Policy should be invoked. Unless there are specific indications to the contrary or the patient/their family requests other arrangements, a series of ongoing open discussions between the staff providing the patient's care and the patient and/or their relatives or carers should take place with all due care taken to take account of individual needs. All Root cause analysis reports generated from all types of incidents should contain evidence of compliance with the framework.

The provider is to comply with the national Patient Safety thermometer census administered by the SHA. Comply with NRLS data quality standards 2009 on incident reporting. The provider will supply the commissioner with a quarterly compliance report for these standards reported to the Quality review meeting.

Provide the commissioner with a quarterly report of the total number of patient safety incidents by type, cause group site and severity. Any trends should be highlighted, with appropriate learning outcomes. The report should also contain details of any care episode in which the patient suffered two or more of the four QIPP safer care harms [Pressure Ulcers, CUTI's, falls and VTE's]. The commissioner may request any action plans related to identified significant trends.

Provide the commissioner with a quarterly report on PALS enquires, Complaints and Litigation claims. This should include numbers, type and specialty, with the percentage of reported incidents leading complaints and complaints proceeding to litigation. Any trends or significant issues should be highlighted and the report should include an action plan to demonstrate how the patient experience is being used as a catalyst to improve services.

Notify the Commissioner immediately any suspected serious incident (SI) (previously referred to as Serious untoward incidents) is detected. The provider will then have 2 working days to ascertain if the incident is an SI and enter the SUI onto STEIS. The provider will be expected to report on exceptions at the time of occurrence and provide quarterly data on compliance.

Report any Care Quality Commission alert letters as SIs following the normal SI process.

Ensure all SIs have a root cause analysis undertaken using the NPSA standard template, with appropriate implementation of Being Open processes where harm has occurred. A report and action plan should be completed. This must be shared with the Commissioner within Nationally agreed timescales. The commissioner will review the report agreeing closure or requesting further investigations/actions which must be submitted within a timescale agreed with the commissioner.

Use the NPSA root cause analysis (RCA) final report template as a minimum standard for SI reports submitted to the commissioner. If the Provider wishes to deviate from NPSA standard, agreement must be sought from the commissioner SI scrutiny group. Action plans should include all issues identified in the RCA with appropriate actions, responsible individuals and action dates. The commissioner's SI scrutiny group will report any exceptions to the quality review meeting. The Commissioner will expect providers to monitor progress against action plans through to completion and will expect the provider to submit any exceptions against action plans on a monthly basis. The commissioner has the right to monitor progress against action plans through to completion related to any SI or other event deemed significant and will expect the provider to submit updates against all actions on a monthly basis when requested.

Allow the commissioner to audit a number of SIs at the 6 month and 1 year points to assure compliance with stated action plans. This will involve review of appropriate documentation and on site visits. This audit will consist of a mix of random SIs and specific high risk SIs. Findings including exceptions will be reported to the Quality management Committee.

Comply fully with the commissioner's Management of commissioned providers SIs policy and SHA Serious Untoward Incident and Notifiable Issues Guidance. Where the two documents diverge the PCT policy will take ascendance. These policies will be based on the NPSA national Framework for Reporting and Learning from serious Incidents Requiring Investigation and NPSA being Open Framework. Where a commissioner or SHA policy/Guidance deviates from the national frameworks providers should seek clarification from the commissioner.

Allow the commissioner to audit the provider's SI/incident and being open policy and procedures to ensure compliance with the Commissioner: Management of commissioned providers SIs policy and NPSA national frameworks. Policies deemed non compliant will be reported to the quality review meeting.

If a patient or service is registered with a CCG other than the lead commissioning CCG ensure the CCG in which the patient lives and/or the incident occurred is supplied to the lead commissioner, and supply all relevant information when closure is requested.

Comply with all appropriate CAS safety alerts, reporting quarterly on compliance with alerts to the Patient Safety lead. Any exceptions should have action plans with responsible individuals and action dates reported to the quality review meeting.

Allow the commissioner to audit a number of CAS Safety alerts at the 6 month and 1 year points to assure compliance with required actions. This will involve review of appropriate documentation and on site visits. This audit will consist a mix of random Alerts and specific high risk Alerts. Findings including exceptions will be reported to the quality review meeting.

In order to foster a culture of learning and sharing of learning from such incidents the Commissioner will not use the numbers of SIs reported to performance manage the provider (although this is without prejudice to the Commissioner's general right to performance manage for breach). Rather failure to inform, failure of Being Open processes as part of an investigation where harm has occurred, failure to carry out root-cause analysis or carry out action plans will be performance managed.

Work with Adult Social Care to Safeguard Vulnerable Adults by undertaking the responsibilities in the Multi-Agency Policy and Procedures for Safeguarding Vulnerable Adults 2007 and Operational Instructions. This policy sets out the responsibilities for staff reporting incidents of suspected adult abuse in relation to SI and incident reporting. The Provider will comply at all times with the Sussex Multi-Agency Policy and Procedures for Safeguarding Vulnerable Adults and undertake reporting as agreed in respect of this policy. The Provider will continue to work with the Commissioner and Local Authorities to harmonise the SVA and SI processes and to ensure that SVA and SI investigations inform each other and that the outcomes of these investigations are shared where necessary. Similarly, the Provider will work with the Commissioner to ensure harmonisation of the safeguarding children processes with SI process.

The provider will supply the commissioner with a quarterly report pertaining to all adult safeguarding incidents reported to any local Authority. The report should contain the total number of adult Safeguarding alerts raised in respect of the Trust by type, cause group site and severity. Any trends should be highlighted, with appropriate learning outcomes, area, local Authority area and level of alert. All level 3 and 4 alerts should be listed with details of the alert. The commissioner may request any reports and action plans related to significant alerts. NHS West Sussex may attend any multi

agency meetings in relation to an alert and reserve the right to suspend a service if patient safety is compromised.

Provide the commissioner with a quarterly report of the total number of referrals to HM Coroners service. Any trends should be highlighted, with appropriate learning outcomes. The commissioner must be informed of any Rule 43: Coroner reports to prevent future deaths requirements. The commissioner may request any reports and action plans related to significant inquests.

Where a commissioner believes that a particular SI raises special concerns, it shall notify the Provider of this. The Provider will be required to discuss and agree the scope, conclusions and recommendations of the investigation with the commissioner. The commissioner may require the Provider to:

Produce an interim action plan within 3 operational days of a request to do so
And/or submit further reports within 3 operational days of a request to do so
And/or attend meetings with regard to implementation of the action plan within 3 operational days of a request to do so

Report all NPSA defined Never Events as SIs. A full list of current Never Events is listed by the NPSA.

4.2 Facilities and Equipment

- A full list of equipment is detailed in Appendix 2.
- The Providers facilities / premises must comply with the relevant requirements as set out by the Care Quality Commission and as set out in the Contract for NHS Services

The service should be delivered in a suitable clinical environment which meets the standards within Health and Social Care Act 2008 and its associated “Code of Practice for health and adult social care on the prevention and control of infections and related guidance”. The environment should include;

- A designated clinical hand wash basin that conforms to current recommended guidance (HTM64)
- Access to a dirty/clean utility area with a designated decontamination sink.
- Adequate closed storage for equipment.
- Appropriate flooring impermeable to spillage or contamination from blood, body fluids or chemicals and should be easily decontaminated.

If the environment to be used is a multifunctional clinical area; the service should undertake adequate risk assessments and ensure that the cleaning schedules are fit for purpose between changes of the clinical rooms function. Cleaning schedules must

be in place detailing daily, weekly, monthly, quarterly, annual cleaning regimes. An Infection Prevention and Control programme of audit should be in place.

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- All equipment where appropriate should be regularly maintained to relevant national or international requirements and undergo regular checks (Stage A, Stage B or Stage C checks) in accordance with national recommendations
- Equipment and electrical connections should meet the NHS requirements of safety of equipment used with patients and comply with the relevant NHSE recommendations

All equipment and medical devices necessary to deliver this contract must be provided, maintained and calibrated by the service provider in accordance with the manufacturers' instructions and current national or local best practice guidance. All medical devices must comply with the 'Essential Requirements' provided in the Medical Devices Regulations 2002."

The service must have a system in place which ensures that all medical devices intended for single use are not reprocessed for reuse.

The service should have all equipment detailed on a cleaning schedule

All infection prevention and control standards, decontamination measures and sterilisation of equipment must comply with the standards within Health and Social Care Act 2008 and its associated "Code of Practice for health and adult social care on the prevention and control of infections and related guidance".

4.3 Governance

The provider is required to have in place:

- An organisational structure that provides leadership for all professions and disciplines involved in delivery of the services
- Clear organisational and integrated governance (including clinical governance) systems and structures with clear lines of accountability and responsibilities for all functions
- A named professional head of service/clinically accountable director with responsibility for:
 - Operational and clinical governance within the service including clinical management and quality assurance

- Ensuring continual review of the direct access health care service

The Provider must allow the Commissioner, or any individual or organisation acting on the Commissioners' behalf (e.g. Local Health Watch or LINKs groups), to inspect the quality of services through observation of service delivery, audit of patient records and data, audit of business processes and records relating to the Leg Ulcer Service contract and audit of staff records, annually or if requested.

The provider will record and monitor levels of patient satisfaction with the service and identify themes, trends and areas for improvement at the beginning and end of each total patient care episode for active ulceration or at minimum of 6 months. (i.e. at start of treatment and healing – or at least 6 months if not healed)

The Provider will supply the results of surveys in full along with action plans for service improvement based on the outcome of patient surveys to the Commissioner on an annual basis

Patient surveys will include questions around access, communication, quality and overall experience

4.5 Marketing and Promotion of Services

Providers marketing and promoting their NHS services should adhere to the 'Code of Practice For The Promotion of NHS-Funded Services'.

The Provider will:

- Undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service. Both the Commissioner and the Provider have the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service.
- Comply with NHS branding guidelines when producing communication, marketing and patient promotion literature which may include branding as an accredited provider to the NHS where non NHS organisations (e.g. social enterprises) hold the contract.
- Any communication, marketing and promotional activity must be separate from other non-NHS funded services marketing and promotion activities.

- Not pro-actively promote non NHS-funded services, activities or products which could be considered to be an alternative option to NHS provision to NHS patients using the Leg Ulcer Service.
- Not market NHS products and services as inferior to other products or services they or any organisation in which they have an interest provide.
- Offer patients an opportunity to opt into receiving marketing information, and not make future contact without the patient's explicit opt-in consent.

5. Key Service Outcomes

Key Service Outcomes are:

- Healing rates based on the number of patients and the length of time they take to heal
 - To heal a minimum of 90% of leg-ulcers on care pathway 1 within an 12 week period (one cycle of care)
 - To heal a minimum of 70% of leg- ulcers on care pathway 2 within an 18 week period. (one cycle of care)
 - To heal a further 10% of leg ulcers on Care Pathway 2 within a further 14 week period (second cycle of care)
- Access for example achieving appointment targets
 - Patient to be contacted within 3 working days and offered an appointment within 10 working days of the referral being received for 100% of initial assessments.

Other Outcomes / Measures / Reporting Requirements will include:

- Visibility of the number of cycles of care by patient on Care Pathway 2.
- Patient reported quality of life using a validated HRQoL tool e.g. CWIS
- Patient satisfaction/complaints
- Assessment of concordance and healing rates rate at 4 weeks
- Others to be determined by and agreed with local commissioners – see Appendix 1 for example reporting template. These will include (but not limited to):
 - Rates of recurrence

- Infection rates
- Onward referral to secondary care
- Total number of referrals
- The number of patients who are designated Care Pathway 1 and 2 (with reason / rationale)
- Patient reported outcomes measures (PROMs)

Leg Ulcers and Wound Healing
Service Specification Appendices

Appendix 1 - Reporting Information

Commissioners will agree the exact requirements for reporting with accredited providers.

A template will be provided for the information to be recorded and there will be an expectation of weekly activity monitoring and monthly monitoring against all key performance indicators.

Appendix 2 - Equipment and Software

The provider should provide all equipment for assessment and management of the presenting conditions and ensure appropriate software for the recording and export of patient data including a minimum of:

- Doppler Ultrasound machines and accessories with ultrasound gel or other equipment for assessing patency of arterial supply. Doppler machines should be decontaminated after each use.
- Sphygmomanometers and a range of cuff sizes – covers for cuffs if to be used over open wound. Cuffs should be decontaminated after every use and preferably single patient use if open wounds.
- Cling film
- Disposable or cleanable tape measures
- Adjustable height couches or chairs
- Blue towel roll
- Nurses stools
- Single use plastic aprons and gloves including non-latex
- Storage facilities for equipment
- Compression system and interactive dressings, tapes and tubinette, skin care products, soap substitutes, cleansing solutions, syringes for irrigation, dressing packs and supplementary items
- Buckets and bucket trolleys. Disposable impermeable liners should be used in buckets and disposed of between patients. Buckets and trolleys should be decontaminated between use and at the end of the session.
- Hand washing sinks, liquid soap and paper towels must be dispensed from wall mounted dispensers adjacent to sink. Alcohol hand rub should be available at the point of patient care.
- There are foot operated fully enclosed, lidded bins for healthcare waste, waste should be segregated and disposed of in accordance with the HTM 0701.
- Scissors for outer bandaging single patient use and cleaned between uses. Scissors should be sterile and single use for all primary dressings.

- Sharps containers should be available for use as specified by the BS 7320 and UN 3291, sharps waste should be correctly segregated.
- Sluice sink for disposal of dirty water
- Stainless steel dressing trolleys
- Detergent impregnated disposable wipes and 70 % alcohol disposable wipes.
- Appropriate detergents and disinfectants.
- Refreshment facilities
- Wound swabs
- Diagnostic tests for testing levels of MMPs
- Magnified overhead light
- Weighing scales and height measure / callipers if patient not able to be measured standing
- Waiting area with health promotion materials
- Camera
- Consent forms with 3 levels of consent
- Digital measurement technology
- Tracing materials
- Thermometer
- Documentation
- Computer (for viewing results, entering patient data, storing photographs etc.)
- Computer hardware and software of a sufficiently robust to support the above systems, including secure back up facilities of all patient data
- Moving and handling equipment e.g. hoist/slings/PAT slides/Leg supports/lifters
- Hosiery application aids
- Health promotion materials

- First Aid Kit
- Any other equipment necessary

All equipment must be detailed on a cleaning schedule

Appendix 3 – Quality Indicators

Part 1 - Quality Requirements

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach
Clinical Quality Healing Rates	The proportion of patients as a percentage whose wound heals at: 12 weeks for Care Pathway 1 18 weeks for Care pathway 2	Minimum 90% 70 or 80%- we need to test at RFI	Monthly performance reports	Performance Management via Contract Management Clause
Clinical Quality Acquired Infection	Patients who acquire an infection during treatment / care Pathway	No avoidable MRSA Blood stream Infections.	Monthly performance reports	Performance Management via Contract Management Clause

<p>Access</p> <p>Referral to assessment time</p>	<p>Assessments to be completed within 10 working days following receipt of referral, unless patient requests otherwise.</p> <p>Urgent referrals are assessed within 3 working days following receipt of referral, unless patient requests otherwise.</p>	<p>100%</p> <p>100%</p>	<p>Monthly performance report</p>	<p>Performance Management via Contract Management Clause</p>
<p>Access</p> <p>Information sharing</p>	<p>Patient records and associated letters/reports completed and sent to Referrer within 5 working days of assessment / follow-up</p>	<p>95%</p>	<p>Monthly performance reports</p>	<p>Performance Management via Contract Management Clause</p>
<p>Access</p> <p>Reducing Inequalities</p>	<p>Patient questionnaire demonstrates a high satisfaction rate from all protected characteristic groups (PCGs)</p>	<p>95%</p>	<p>Annual service user consultation questionnaire analysis, specifying overall satisfaction levels for PCGs</p>	<p>Performance Management via Contract Management Clause</p>

<p>Access</p> <p>Reducing Barriers</p>	<p>An integrated patient pathway, which facilitates signposting to wider communication/social support services (where appropriate)</p> <p>Provider provides demonstrable evidence of % patients who receive information about these support services</p>	100%	Annual Reports	Performance Management via Contract Management Clause
<p>Quality</p> <p>Service user experience</p>	<p>Standardised patient questionnaire to be issued at discharge.</p> <p>95% of respondents should report overall satisfaction with service.</p>	100%	Quarterly/ bi-annual (provider preferred) and accumulative annual report to include an analysis of completed user questionnaires, demonstrating % of those satisfied or very satisfied with service.	Performance Management via Contract Management Clause
<p>Quality</p> <p>Peer satisfaction of service</p>	<p>A minimum of one referrer satisfaction survey will be designed and sent to all referrers 95% of respondents should report overall satisfaction with service</p>	95%	Annual report to include an analysis of completed user questionnaires, demonstrating % of those satisfied or very satisfied with service.	Performance Management via Contract Management Clause

Quality Service improvement	Service user questionnaires (PROMS) and peer satisfaction surveys to capture areas for improvements. 100% of recommendations made and agreed with Commissioners are addressed	100%	Annual report to demonstrate recommendations and actions taken to address areas of service improvement	Performance Management via Contract Management Clause
Quality Personalised Care Planning	All patients have an Individual Management Plan	100%	Monthly performance report	Performance Management via Contract Management Clause
Quality Improved quality of life	Patient QOL questionnaire a. Beginning (start of treatment) b. 12/18 weeks (end of treatment)		Annual report	Performance Management via Contract Management Clause

Appendix 5 - Tariff for care packages (to be revised)

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Appendix 6 – Information requirements for patients

Background

In response to the NHS Future Forum listening exercise, the Government has confirmed its commitment to the increased choice and personalisation of NHS funded services. Extending patients' choice of healthcare provider is intended to empower patients and their carers, improve their experience of NHS funded services and improve health outcomes.

The Government has specifically committed to extending patient choice of Any Qualified Provider (AQP) for appropriate services. Following engagement from a wide variety of patients, carers and patient representatives it has been identified that as providing choice for patients re community services is something new for patients they are unsure of the type of information that they would require to make an informed choice particularly service specific information.

Generic Service information

- Details of the service provider e.g. how long you have been established, workforce, Patient testimonials etc
- Information about the service itself, types of treatment available
- Choices in provision of care e.g. location, flexibility of appointments, availability of male female nurses etc
- Access and referral
- Timescales for treatment
- Waiting times
- Information about expected outcomes

Provider specific information

- Information on range of products and suppliers e.g. dressings and Compression
- Quality assurance and requirements of care information (including service user experience data, skill-sets and qualifications of specialist nursing staff) in particular, demonstrating the availability of competent , knowledgeable caring

staff as these were all classed as being very important to users of the Leg Ulcer services

- Other quality ratings e.g. Health and Safety requirements for moving and handling

Essential

- Information should be accessible to all groups
- Information should be kept simple, presented clearly and be understood by all service users regardless of age, ethnicity, disability and be available in a range of formats should consider the needs of people with dyslexia when selecting colours and fonts.
- Providers should communicate information about their services through a range of communication channels
- Information provided should adhere to the rules around NHS branding
- Add tables to include information and collateral that will be available to patients under the following headings:
- Information and Collateral at Point of Referral for example: Provider Type, Location,
- Information pertaining to starting treatment under AQP for example: Overview and Suitability, Pathway considerations including setting of care , not attending, feedback and complaints
- Provider specific patient information and collateral for example provider generated information and interface services where applicable
- Self-Care Advice including the importance of concordance

Appendix 7 – Information for providers on demographics and potential clinic venues

The North of West Sussex consists of two clinical commissioning groups (CCG) covering a total population of c349,400 patients. There are 12 practices within the Crawley CCG and a total of 23 in Horsham & Mid Sussex CCG.

Within the Crawley area there are significant areas of deprivation with a generally younger population than the UK average. However this is set to rise significantly over the next few years. There is a large ethnic population consisting of mainly Asian/Indian and Eastern Europeans. There is a larger than average prevalence of diabetes in Crawley.

Within the Horsham & Mid Sussex CCG there is a large elderly population living independently in their own homes throughout a mixture of urban and rural areas.

In addition to Primary Care practice locations, there are health centres in Haywards Heath, Burgess Hill, East Grinstead and Crawley. In Crawley and Horsham there is access to large community hospitals.

It is recommended that providers should seek to secure agreement with practices and/or health centres if they wish to utilise premises to run leg ulcer clinics. A full list of practice contact details can be provided upon request.

Practices within the localities that have expressed a potential interest in hosting a clinic are as follows:

Crawley	Contact details
Horsham	
Mid Sussex	

Appendix 8

Maintenance pathway

AQP venous leg ulcer (VLU) and extended wound service (this includes mixed, arterial and post-surgical wounds)

Providers must seek approval from the commissioner before assigning a patient to the maintenance pathway. Patients receiving a maintenance pathway will be reviewed by the CCG on a monthly basis. It can be used for both the venous leg ulcer and mixed/arterial ulcer service.

VLU;

- Patients deemed by the provider/or GP as requiring a maintenance pathway need to receive agreement from the CCG prior to commencement.
- Once a patient is on a maintenance pathway defined by the provider this will be communicated to the GP. Updates on the maintenance pathway will be required on a quarterly basis to the GP or if the clinical picture changes or if the GP requests more regular updates.

Arterial/Mixed wound

- Patients deemed by the provider/or GP as requiring a maintenance pathway will need to have a pathway defined by the provider
- The maintenance pathway will be communicated to the GP. Updates on the maintenance pathway will be required on a quarterly basis to the GP or if the clinical picture changes or if the GP requests more regular updates.

Inclusion criteria;

- Patients who were discharged from the AQP provider more than 6 weeks prior
- Patients who have a deteriorating wound, or a wound that is not responding to treatment
- Patients who have high levels of exudate which cannot be managed by the practice nurse
- Patients who have been assessed by the vascular team and diagnosis confirmed as arterial / mixed, but with no vascular intervention planned

Exclusion criteria;

- Patients who have been non-concordant with AQP providers on two or more occasions
- Those patients whose wounds can be managed by the practice nurse in the surgery (i.e. basic wound dressings only, for Horsham and Mid-Sussex only)
- Those patients who have been seen by the AQP provider and whose wound is deemed to be static (palliative).