# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.*

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| **Service Specification No.** |  |
| **Service** | Lymphoedema Service |
| **Commissioner Lead** | Helen McConville |
| **Provider Lead** |  |
| **Period** | April 2023 |
| **Date of Review** | September 2023 |

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| 1. Introduction |
| **1.1 Lymphoedema**  Lymphoedema is chronic swelling due to failure or incompetence of the lymphatic system. It most commonly affects the lower or upper limbs, but may also affect other areas including the head and neck, trunk, breast or genitalia. Chronic oedema is often used interchangeably with the term ‘lymphoedema’. Whilst chronic oedema may result from different pathologies it is important to note that ALL chronic oedema is in part a failure of the lymphatic drainage. The condition affects individuals of any age, gender or ethnicity. Insufficiencies in the lymphatic system may be due to a congenital lymphatic abnormality (primary lymphoedema) or damage caused by cancer (or cancer treatment), infection, trauma (e.g. joint replacement/venous grafting, chronic venous insufficiency, DVT and obesity (secondary lymphoedema). Lipoedema is another chronic swelling (abnormal fat disposition) that is frequently seen in women.  The exact prevalence of lymphoedema is unknown. Studies in Derby found a prevalence rate of 3.93 per 1,000 population, rising to 28.75 per 1000 in the over 85-year age group. The Lymphoedema Network in Wales has reported increases in prevalence over the last 6 years, rising from 2.6 to 6.4 per 1,000 population; incidence and prevalence continues to rise on an annual basis. Assuming a modest rate of 5.00 per 1,000 population, MBCCG would have approximately 1,750 people with lymphoedema.  **1.2 Lymphoedema Service**  This is a comprehensive service designed to deliver specialist intervention to patients who have cancer-related and non-cancer-related lymphoedema.  Through utilising a competent and skilled workforce and providing seamless care in core and specialist practice, the lymphoedema service will provide a safe, effective and person-centred service to achieve maximum improvement that empowers sufferers with the necessary skills to self-manage and optimise their swelling. Aims include:   * Reduction and control of the oedema * Prevention of infection (cellulitis) and avoidance of hospital admission * Prevention of lymph leakage (lymphorrhoea) and other skin tissue changes e.g. hyperkeratosis * Improvement and maintenance of function and mobility of the affected, swollen area * Resolution of symptoms such as pain, heaviness and ache * Provision of information to enable patients to make informed decisions about their care * Education and empowerment of patients to self-manage their care * Support and reduce psychological distress * Enhancement in quality of life * Health and well-being, including weight loss in cases of obesity, encouragement of smoking cessation when appropriate   The service excludes those with a wound associated with CVI (leg ulceration) – though an advisory appointment can be offered.  Those with a morbid obesity (BMI> 40) are also excluded unless they also have a unilateral true lymphoedema. Patients with a BMI >35-40 should also be enrolled on a weight reduction programme.    These services are commissioner led. Any significant changes proposed by the provider to the service will be discussed and agreed with the commissioner prior to implementation. Minor changes or temporary changes to accommodation operational issues should be notified to the commissioner as part of the service issues log discussed at the contract meetings.  **1.3 The commissioning vision**  The CCG has a vision of commissioning on a population based healthcare need, based on Integrated Care Communities and registered populations in networks of GP practices (PCNs)  It is fundamental that there is a reliable relationship between the providers’ staff and each Integrated Care Community and every general practice in the CCG area**.**  Managing resources Bay-wide and at the local level will depend on reliable timely data and information. Provision of this is a priority |
| 2. Population Needs |
| **2.1 National/local context and evidence base**  The publication of the NHS Long Term Plan and supporting strategy documents aims to address the health and wellbeing gap, the care and quality gap and the funding and efficiency challenges in the context of rising demand for health and social care.  **2.2 Lancashire and South Cumbria Strategic Context**  Healthier Lancashire and South Cumbria is a partnership of organisations working together to improve services and help the 1.7 million people in Lancashire and South Cumbria live longer, healthier lives.  The partnership is made up of Local Authority, Public Sector NHS and voluntary and community organisations coming together to improve outcomes and care for local people, reduce pressures on services and make best use of our financial resources.  In delivering care closer to home and supporting patients in the community, health and social care partnerships have invested significantly to enable responsive services that have shifted settings of care into the community.  Providers must be capable of working across the 8 Primary Care Networks in Morecambe Bay. |
| **3. Outcomes** |
| **3.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | Domain 1 | Preventing people from dying prematurely | **Y** | | Domain 2 | Enhancing quality of life for people with long-term conditions | **Y** | | Domain 3 | Helping people to recover from episodes of ill-health or following injury | **Y** | | Domain 4 | Ensuring people have a positive experience of care | **Y** | | Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | **Y** |   **3.2 Locally defined outcomes**  Service user outcomes are dependent on the Clinical Model for services.  **3.2.1 Principles underpinning the Clinical Model**  The lymphoedema service should work seamlessly alongside primary care with reference to:   1. Reflect the ‘community’ and have a strong sense of local place 2. Be based on what matters to each patient 3. Suit the type and preferences of patients. This can mean different modalities for different types of patients. 4. Be delivered by professionals at the top end of their licence, enabling primary care to focus on population health management and acute teams to focus on people requiring specialist provision 5. Be delivered in a way that constantly improves health outcomes of the population, by providing high quality of care, efficiently and within financial control targets   The overall objective of treatment is to achieve maximum improvement that empowers people with lymphoedema with the necessary skills to self-manage.  The provider will be required to demonstrate how patients with mental health issues or with learning disabilities have parity of esteem in access to and benefit from services as other patients. |
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| **4. Scope** |
| **4.1 Location(s) of Service Delivery**  The service will operate flexibly to provide a five-day service. Clinics are currently provided at:  St. John's Hospice  Slyne Road  LA2 6ST Lancaster  Lancashire England  Furness General Hospital (Oncology)  Dalton Rd  Barrow in Furness  LA14 4LF  UK  St Mary’s Hospice  Ford Park  Ulverston  LA12 7JP  UK  **A further clinic will need to be provided in the Kendal area for South Lakes Residents**  **4.2 Days/Hours of operation**  The service will operate flexibly over 5 days a week (excluding Bank holidays). Between 8:00 – 20:00hrs (as required) – but generally 8:30 – 17:00hrs  **4.3 Contract Value, activity and waiting times**    The cost of providing a lymphology service for patients will be agreed prior to service commencement and reviewed against current and proposed activity.  Cancer: 168 New patients and 1,167 follow-ups per year  Non-cancer: 1383 treatments performed. Approximately 122 patients will be discharged from the service.  Waiting times from receipt of referral to initial appointment are as follows:  • Palliative patients: assessment: 1-2 weeks; treatment: immediate  • Non-palliative, urgent patients: assessment: 2 – 3 weeks; treatment: within 1-2 weeks after assessment  • Non-urgent, non-cancer: assessment: 8-12weeks; treatment within 2 weeks after assessment  There are currently 544 active patients on the caseload – including cancer and non-cancer patients.  It is agreed that the contract value will be a fixed annual sum based on 22/23 forecast. Contract will be reviewed in the event of activity changes +/- 10%  **4.4 Aims and objectives of service**  The lymphoedema service provides appropriate expert assessment, treatment, support and instruction to patients registered with a NHS Morecambe Bay CCG GP. Registered staff are trained to assess, diagnose and treat as autonomous practitioners. Clinical leads and specialist practitioners will be required to have undertaken additional appropriate post-graduate training.  All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety as detailed by the Care Quality Commission.  **4.4.1 Service aims:**  The International Lymphoedema Framework recommends standards for lymphoedema services that align with the NHS Outcomes Framework. Lymphoedema service provision will be, therefore, in line with the International Lymphoedema Framework and pertinent health policy, enabling a prompt, equitable access to treatment for all patients suffering from, or with, a life-time risk of the development of swelling.  Patients at risk of developing lymphoedema should receive advice from a health care professional with the training required to meet the need. Information should include the signs and symptoms that may indicate the onset of lymphoedema, and contact details from whom to seek advice should swelling commence.  Patients who have developed lymphoedema should be assessed by a registered health professional with accredited training in the management of lymphoedema. The objective being to determine the cause of the swelling (differential diagnosis) and organise treatment in accordance with each patient’s clinical need. Key to the success of treatment is the setting of realistic goals for each patient and empowering them with the knowledge and skills to self-manage. Patient education should, therefore, include written literature, treatment instruction and personalised care plans.  An holistic approach to assessment also facilitates referral to other health disciplines to address other factors likely to affect treatment outcome e.g. physiotherapy, dietitians, and leg ulcer services to treat loss of function and open wounds respectively.  **4.4.2 Treatment objectives:**  Patients can be referred by their GP or Health Care professional and treatment is provided according to individual need. Self-referrals require GP consent  The overall objective of treatment is to achieve maximum improvement that empowers sufferers with the necessary skills to self-manage and includes:   * Reduction and control of the oedema * Prevention of infection (cellulitis) and avoidance of hospital admission * Prevention of lymph leakage (lymphorrhoea) and other skin tissue changes e.g. hyperkeratosis * Improvement and maintenance of posture, gait and limb function and mobility of the affected, swollen area * Resolution of symptoms such as pain, heaviness and ache * Provision of information to enable patients to make informed decisions about their care * Education and empowerment of patients to self-manage their care * Support and reduce psychological distress * Enhancement in quality of life * Health and well-being, including weight loss in cases of obesity   Essential components of treatment include:   * Care of the skin: to maintain integrity and prevent infection * Movement/physical activity: to stimulate muscle pump activity to enable lymph fluid drainage and enhance range of movement * Compression garments: to control and further reduce oedema * Multi-layer bandaging and Velcro wrapping systems: to reduce severe swelling, skin changes and shape deformity * Manual lymphatic drainage, for oedema affecting the body trunk/head and neck. * Simple lymphatic drainage: to encourage lymph flow * Weight management advice   There will be a requirement to have an appropriate booking system that allows telephone booking Monday to Friday and generates a patient record that enables outcome based and performance data to be collected.  **4.5 Workforce**   * Professional staff using one or more designated titles that are protected by law must be appropriately registered to use them and maintain registration and competence by a program of ongoing CPD.   All staff   * Are expected to receive clinical and managerial supervision and support for professional and specialist development. * Are expected to have an annual appraisal (PDR) with their line managers and personal development plans agreed to enable individual development to meet competence, HPC registration requirements and to support service development.   All new staff must attend the local induction programme.  It is not the Commissioner’s intention to prescribe the exact skill mix and structure of the team – the Provider will ensure the necessary skills and competencies are in place and the staff are supported and supervised, professional and able to work independently where required including alongside clinical and non-clinical colleagues in primary and acute care.  The service will ensure that staff with the required knowledge, skills, competence and experience are in place to deliver the required assessment, care management and treatment.  The Commissioner is not specifying specific roles or nomenclature, but there will be a need for staff of the experience and capacity to work with a wide range of colleagues in health and social care to facilitate case finding, care planning, onward referral or discharge and support for self-management.  Working with partners and looking across all care needs in the community, the service will, with the Commissioner, design and implement innovative roles to support service delivery.  The service shall give consideration to greater involvement of outside agencies (if necessary through subcontracting or as contracting partners) in the delivery of services traditionally associated with the lymphoedema service. This could include voluntary sector/social care/care home staff with appropriate training.  The service shall ensure that clinical staff (including students) are provided with adequate clinical supervision and are supported to complete continuing professional development. This will take into account relevant health professional expectations and standards  The service will be expected to act as the main source of professional support and motivation for lymphoedema services working across the Bay Partnership. This will include leading on facilitating and supporting joint forums, making training available and ensuring new ideas and innovation are shared.  **4.5.1 Staffing characteristics**  Providers will be expected to demonstrate approaches that successfully recruit and retain staff locally in the face of competition and other challenges. This may be achieved by developing the level of professional support, establishing academic links, allowing autonomy and a local level, introducing greater flexibility over an extended working day and developing, where possible, shadowing arrangements with practices.  The staffing model should ensure staff have the following key characteristics:   * Resilient and adaptable, able to cope with unpredictable situations. * Confident in making autonomous decisions * Skilled at proactive engagement and intervention, working with individuals and carers to enable them to recognise acute or chronic changes in their condition or wellbeing, using advanced practice skills for assessment, diagnosis and appropriate intervention * Focused on patient and carer-centred delivery.   **Ability to work with others**   * Skilled and effective at working in partnership as a member of the wider healthcare team * Able to work effectively with patients and carers to support them in their role to meet person-centred outcomes. * Strongly focused on enabling individuals to take responsibility for their self-care (skilled in behaviour change or coaching strategies to support individuals to be empowered and confident in managing their conditions**).**   **Safe working and safeguarding**   * Able to conduct risk assessments and design risk mitigation to ensure interventions can be delivered safely to people in primary and secondary care * Able to recognise where safeguarding or mental health is compromised and able to assess an individual’s mental capacity to consent * Confident in higher level communication to enable negotiation of care plans in the interests of creating the most effective collaborative relationships.   **Technology and information**   * Effective users of technology, promoting its use with people in their care (see also section below) * Able to apply population level health and wellbeing initiatives and to understand the full nature of the population served and to contribute to stratification or targeting. * Able to use appropriate outcome measures to evidence the effective use of lymphoedema services   **4.6 Technology**  The service should have a clear strategy for the use of technology. Staff at all levels should be involved in regular activity and outcome review. The service will contribute to monthly dashboards held at local and network levels and be prepared to discuss with primary care partners and others priorities and resource use. Dashboards will include activity, outcome and cost information  **4.7 Service description/care pathway**  The service will identify the person accountable for all services delivered to the local network. It is expected that major resource decisions (for example, in response to any short term change in demand or capacity) will be taken by the service after consultation with the respective commissioning lead.  **4.8 Referrals**  **All referrers will be asked to evidence lymphoedema service need in their referral.**  The service will be accessed through a Single Point of Access (SPA) and the service will see all patients registered with a NHS Morecambe Bay CCG GP.  Referrals to the service should be accepted from designated health and social care professionals including:   * General Practitioners, practice nurses and community nurses * Inpatient services * Specialist Nursing Services   Referrals will be triaged by a senior practitioner according to service guidelines, and will be allocated to the relevant clinic or service.  **4.9 Assessment and Case Management**  The lymphoedema service provides appropriate expert assessment, support and instruction to patients registered with a NHS Morecambe Bay CCG GP. Registered staff will be trained to assess, diagnose and treat as autonomous practitioners. Clinical leads and specialist practitioners will be required to have undertaken additional appropriate post graduate training.   |  |  | | --- | --- | | **Nominated service practitioner** | * Agreeing personal goals and outcomes * Developing care plan in conjunction with primary health care if required * Reviewing and updating the care plan * Coordinating care and support (working where relevant with for the local care co-ordinators and wider Integrated Care Community teams/specialist services) | | **Ensuring access to care plan** | Ensuring:   * An up to date care plan is available in the patients home * An up to date care plan is appended to the practice system record * An up to date record of visits to patients, activities, therapies and interventions provided can be made available contemporaneously to practitioners if required | | **Communication with primary care practice** | * Will communicate appropriately with the patient’s GP using secure (e.g., NHSmail) communication methods | | **On-going holistic assessment** | * Including relevant diagnostics monitoring and treatments for long term conditions as required as part of patient’s on-going package of care, including taking responsibility for following up referrals and investigations. | | **Provision of holistic carers assessments** | * Use of the agreed assessment tools which form part of the care management process * Signposting to the full range of local support for carers |   **4.10 Prevention, self-care and health promotion**  All patients requiring intensive treatment regimens are expected to commit to the provider’s treatment contract. As part of the treatment regimen, Patient Activation Measures will be used to assess patients’ activation to adopt positive behaviours (e.g., diet and exercise), and have clinical indicators (notably BMI) that do not exceed the treatment thresholds (unless confirmation is given by the referring agency that the patient is on a weight reducing programme).  **4.12 Population covered**  Any patient with malignant or unmanaged or problematic non-malignant aetiology lymphoedema/lipoedema may be referred by the Consultant, GP, District Nurse or other HCP (with GP permission). Self-referrals are not accepted. People who have leg ulcers should not be referred solely for the management of their ulcer. There will be clear pathways for transfers of care between the Lymphoedema Service and Community Nursing**.**  The following patients are eligible:   * Patients over the age of 18 years * Patients registered with an NHS Morecambe Bay CCG GP and either living within the CCG boundary or within one mile outside of the boundary * Patients are eligible for NHS care.   In promoting healthier lifestyles, physical, psychological and social well-being the lymphoedema service will encourage service users to live independently and to function as best as possible within the community.  **4.13 Exclusion criteria**   * Patients who are not registered with a GP within the MBCCG area. * Those patients who have a BMI of 35 or over (although there is an expectation of providers to support, in exceptional circumstances, a treatment pathway for lymphoedema patients with a BMI of between 35 and 40 who are undertaking a properly supervised weight management or other programme as a precursor to treatment. This needs to be confirmed by the GP before the referral will be accepted. * Patients with arterial insufficiency * People with leg ulcers whose primary problem is not lymphoedema   **4.14 Interdependence with other services/providers**  The team will work in an integrated and seamless manner with all staff within the Integrated Care Communities. Strong working relationships will be essential with secondary care, primary care and social care to deliver the CCG’s overall ambition of integrated and patient centred care.  In particular, the service will have close links with specialist clinical staff from acute and community services including tissue viability and physiotherapy. This will allow for two-way provision of advice and guidance. Oher interdependencies include:   * District Nurses * Oncology/Cancer services * Leg Ulcer Clinics * Vascular services * Dermatology * Expert Patient Programme and other relevant self-care programmes * Practice Pharmacists * Chiropody/Podiatry   The service will ensure parity of care for patients with mental health issues.  **4.15 Discharge Criteria and Planning**  Following intervention/s when a patient becomes able to self-manage their condition either independently or with the support of a carer or other agency, they are discharged from the service. This may include referral on to other services. If ongoing treatment is required, this should be discussed in detail with the referring clinician prior to discharge. Referrals onward to District Nurses should be notified at least 3 working days prior to discharge.  Following discharge, the GP is informed by letter which includes information on the interventions provided, self-management advice/strategies and recommendations for future management as appropriate.  The Service will be expected to provide the CCG with monthly waiting list information. Discharge letter, summarising treatment given and outcome will be sent to the referring GP within 3 weeks of completion. |
| **5. Applicable National Standards (for example, NICE, Royal College)** |
| **5.1 General:**  There is no NICE guidance on the management of lymphoedema/chronic oedema although it is noted by NICE that the International Lymphoedema Framework has produced such guidance meaning that everyone in the field should be aware of best practice. The condition is mentioned in breast cancer guidance but no others. Notwithstanding this, The service will be delivered within the scope of NHS policies, legislation and instruction, including:   * Health and Safety legislation. * Risk management policy and systems for incident reporting. * MHRA directives around medical devices and equipment safety policies. * Medicines management legislation for the safe handling of medicines and prescriptions. * Public and patient involvement systems and processes to provide information to patients and seek patients’ views on services. * Confidentiality, Caldicott principles, consent procedures, complaints procedures, data protection and information governance policy and protocols * Systems for monitoring activity and staff performance and competency * General and specific NICE guidelines and appropriate professional standards   There is, therefore, a substantial body of statutory and professional standards, guidance and legislation that underpins the Commissioner’s expectations of the lymphoedema service and the following list is intended to be demonstrative and not exhaustive, all relevant NICE guidelines should be adhered to for particular interventions:   * NHS Transforming Cancer Services Team for London (2016) Commissioning Guidance for Lymphoedema Services for Adults Living with and Beyond Cancer * International Society of Lymphology (2013) The diagnosis and treatment of peripheral lymphoedema. Consensus document of the International Society of Lymphology. Lymphology 2013; 46 (1), 84-91 * National Cancer Action Team (2013) Lymphoedema services in England: A case for change. * Relevant Department of Health Prescribed Specialist Services Advisory Group: Recommendations available at <https://www.gov.uk/government/collections/specialised-health-services-recommendations> * NHS England (2016) Commissioning Guidance for Rehabilitation Publication Gateway Reference number 04919 * International Lymphoedema Framework. (2007) Template for Management; * Relevant NHS Outcomes Framework Indicators Available at <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework> * NHS England (2019) the Long Term Plan. Available at: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf> * British Lymphoedema Society (2016) Professional Roles in the Care of Lymphoedema. Available at: <https://www.thebls.com>   **5.2 Tissue viability:**  The provider is expected to have strong professional links with key professionals in the fields of Tissue Viability and Lymphology and collaborate effectively with Tissue Viability services to improve and simplify the pathway for patients with wounds.  Key references include:   * Pressure ulcers: prevention and management (CG179) * Pressure ulcers (QS89) * Relevant Medical Technology Guidance (MTG 5, 17, 20) * NHSI - Pressure ulcers: revised definition and measurement   <https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_2.pdf>  **5.3 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**  This list is intended to be demonstrative and not exhaustive. The provider should demonstrate how it is applying best practice and innovation from a range of sources, notably:   * Health Care Professions Council * Nursing and Midwifery Council   **5.4 Applicable local standards**  **5.4.1 Safeguarding**  The service must ensure that there is appropriate protection of vulnerable adults and children and must adhere strictly to current national policy and local procedures for on the protection of vulnerable adults and children.  **5.4.2 ICT and interoperability standards**  The service provider will be required to be a party to approved Information Sharing Agreements, as required to deliver safe and effective patient services.  The service provider will be responsible for putting in place appropriate information sharing agreements with PCNs and agreed providers of services within the Bay partnership. The format and scope of the ISA should be approved prior to agreement by the commissioner. |
| **6 Performance Targets – Quality, Performance & Productivity** |

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| **6.1 Activity Plan**  Costings for the treatment of lymphoedema are not ‘linear’ as it t is impossible to present the same cost per month, over the period of the treatment. In reality, each client has a clinical pathway:   1. Treatment starts with an assessment of the patient’s needs and clinical position. This will enable the provider to estimate the likely cost of treatment. 2. If there is the need for a course of treatment then the aim is to commence the ‘intensive’ period within 4 week. (Intensive treatment **usually** consists of six to **twelve** sessions on a three to six week basis) 3. All equipment is provided by the GP (using the prescription codes given). An exception to this is the provision of equipment not available on prescription; or provision of bandages and dressings etc. that are required when meeting a patient for the first consultation. 4. One month after intensive treatment has completed, there is a follow up appointment to ensure that the swelling has not regressed and that maintenance/optimisation is possible. Subsequent hosiery/equipment including creams, bandages etc. are requested by GP prescription. 5. During intensive treatment advice/support and education will be given to the patient on how they should manage their condition on an on-going basis. 6. Once a ‘maintenance’ position (i.e. the patient is stable (usually with 18-24 month) is reached the patient should be discharged with a maintenance plan and a letter to the GP explaining the treatment and on-going maintenance plan. The discharge letter will outline required on-going care required to maintain/optimise the condition (including details of the required compression garments available on repeat prescription). 7. Once discharged, patients can attend an ‘advisory appointment’ (should they have a sudden weight increase/decrease for example) to ensure compression garments are appropriately fitting/prescribed. This prevents a re-referral to the service and is charged as a review appointment 8. Provision of compression garments will be via FP10 prescription, except in exceptional circumstances. Other items (such as emollients and bandages) will be requested on FP10 prescription from the patients’ own GP. The average cost of the first compression garments are variable depending on the severity/extent of the lymphoedema -but on average around £180 for below knee garments (x 1 pair). All charges for garments and non-prescribeables will be at cost price.     Details of the following will be provided to the CCG if applicable:   * Any patient who requires a subsequent appointment for any complications following the procedure. * Any patient who is referred to secondary care, either as a result of complications following a procedure undertaken. * The number of patients for whom a repeat procedure is required. * Number of patients / service users. * Number of referrals / waiting list time and numbers. * Age range (define range). * Ethnic origin (using census categories). * Referral areas (geographic / by GP etc). * Comments / Complaints / Compliments. * Income and expenditure in relation to the service.   **6.2 Outcome Measures (routine monitoring)**   * Number of patients discharged on self-management plans. * Number of patients discharged to primary care. * Number of patients in shared care programs with primary care. * Number of patients requiring secondary care intervention. * Following staff training, develop formal process of capturing patient quality of life indicators (WEMWBS; see, for example <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/> or LYMQOL). * Number of re-referrals back to the service.   **6.3 Quality Performance Indicators**   * Care should be consistently high quality and meet the standards identified within the legislative and professional frameworks provided by the National Standards of Practice for Lymphoedema Services, Department of Health and relevant NICE Guidance. * As required, the provider will inform MBCCG of the types of care provision (e.g. intensive course of treatment/ review or follow up). * Referring Primary Care Clinicians will report any concerns re the quality of care provision to the Commissioner of the service. The provider will send monthly data and information to the Commissioner demonstrating numbers of patients seen, care delivered and ongoing care costs. * The provider will share with the MBCCG records of complaints and actions taken on a quarterly basis. Additionally they will also share letters of thanks from patients funded within this agreement or from other relevant clinicians. * This SLA will be reviewed every 4 months. * Providers must report at least quarterly, quality metrics outcomes as issued by the CCG. * Quality must show Effectiveness, Efficiency, Relevance, Access, Acceptability and Equity * To be reviewed at regular intervals |
| **7. Quality and Performance Standards** |

| **Quality Performance Indicator** | **Threshold** | **Method of Measurement** | **Consequence of Breach** | **Report Due** |
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| **Improving Service Users’ & Carers’ Experience** | Service Start Date | Quarterly audit of patient satisfaction | Discussion at Individual complex case panel | Quarterly |
| **Service User Experience:**  Care should be consistently high quality and meet the standards identified within the legislative and professional frameworks provided by the National Standards of Practice for Lymphoedema Services, Department of Health and NICE Guidance. | 0 Complaints  0 SUI | Compliments & Complaints  SUI report | Discussion at Individual complex case panel |  |
| **Unplanned admissions** | Baseline Year | Any patient who is referred to secondary care as a result of complications following a procedure undertaken | Discussion at Individual complex case panel | Monthly |
| **Improving Productivity**  The provider will inform MBCCG of the types of care provision (e.g. intensive course of treatment/ review or follow up. | To achieve a DNA rate of 5% and a cancellation rate of 10%  Number of patients / service users vs. plan  Number of referrals / waiting list time and numbers vs. plan | Monthly report demonstrating numbers of patients seen and type of care provided. | Review appointment arrangements | Monthly |