Minimum Requirements Service Specification

Service	Community chronic pain management service to be known as iHELP which stands for integrated, holistic empowering learning programme
Period	Design phase and pilot phase plus three years with a further two years' option

1. Population Needs

The definition of chronic pain is based on the British Pain Society (2007) definition "Pain that persists beyond the point at which healing would be expected to be complete (3-6 months) or that which occurs in disease processes in which healing does not take place". It focuses on pain of both identifiable and treatable physical conditions and unidentifiable causes.

Chronic pain affects between one-third and one-half of the population of the UK, corresponding to just under 28 million adults, based on data from the best available published studies as published in the BMJ in June 2016. This figure is likely to increase further in line with an ageing population.

NHS West Lancashire CCG has a population of 112,000 patients with 19 GP practices providing primary care and Southport and Ormskirk Hospital NHS Trust being the main provider of secondary health care.

Approximately 800 patients have been prescribed Pregabalin (Lyrica) in 2015/16. Also in 2015/16, approximately 930 patients were prescribed strong opioids for chronic pain.

Approximately 1,390 pain management related procedures were performed in secondary care in 2015/16. Also, approximately 420 patients attended a pain management first outpatient appointment in secondary care with approximately 730 patients having one or more follow up appointments in 2015/16.

These patients are having to see their GP or visit hospital for treatment and pain relief medication as there is currently no specialist pain service for West Lancashire CCG patients.

Often these patients have a broader need than pain relief. For example, they may require advice around physical activity, nutrition and psychological needs. We need a pain service that will manage the full picture of the patients' life and help them self-manage the pain they are experiencing.

Local clinicians are reporting poor patient experience because the GP is unable to address the full needs of the patient within a normal GP appointment. Our GP membership and clinicians have also told us that patients could become dependent on their prescribed medication which could carry a risk to them. Current NICE guidance highlights this as a possible issue.

Current spend on chronic pain (re-costed at 2017/18 tariff levels) is around £3.1 million, representing around £2 million of expenditure on Pregabalin (Lyrica), strong opioids and other analgesics prescribed in primary care and £1.1 million on secondary care (outpatient attendances, inpatient procedures, and day cases).

Annual Pregabalin expenditure accounts for approximately £800k of the prescribing spend for Chronic Pain in West Lancashire. In August 2017, the Category M drug

tariff section was extended to include Pregabalin which has resulted in a significant Pregabalin price reduction. As a result, West Lancashire CCG's annual expenditure on Pregabalin should decrease to approximately £30k. While this means that Pregabalin is less of a financial issue for West Lancashire CCG, there is still a major issue with the underlying level of Pregabalin prescribing which the service would be expected to address. There is also no certainty that this price reduction will be sustained at such a significant level in the long term.

The CCG's commissioning intentions include an aspiration to remodel chronic pain services to help contribute to the triple aim of improved population health, high quality holistic care for patients and reduced cost.

2. Outcomes

2.1 Locally defined attributes and outcomes

NHS West Lancashire CCG has an overarching clinical strategy entitled "***Building for the Future"*** which sets out our vision for joined up care over the next 5 years. This procurement is set in the context of this Vision. As such any service should be developed giving due consideration to the four pillars of this Strategy as set out below:

- Collective accountability.
- Care co-ordination.
- Population management.
- Progressive IT infrastructure.

Also considering working closely with health and social care linking with other services in the health economy as necessary to ensure cohesion and integration for the benefit of patients.

The Vision also describes how it will be essential to demonstrate how services will be provided sensitive to local health and service need, addressing health inequalities, wrapped around the patient and focussed on our neighbourhoods; whilst also contributing to time savings in Primary Care and a reduction in attendance at A&E for chronic pain.

The "***Building for the Future"*** strategy document is available at: http://www.westlancashireccg.nhs.uk/wp-content/uploads/Building-for-the-Future-Sept-2015.pdf.

The Supplier should share the Commissioner's vision for change and be willing to work with the Commissioner to drive the transformational change, understanding the need for whole system transformation including:

- Changing cultural beliefs and behaviours across organisational boundaries and throughout the healthcare system.
- Providing modern and innovative IT enabled healthcare services which supports patients at all levels of complexity to remain at the highest level of independence that they can achieve.
- Integrating a range of health, social care and third sector services.
- Influencing supply chain organisations to deliver better outcomes for patients.

Work with the Commissioner and service users and carers with personal experience of chronic pain specifically to co-design the final version of the outcome based specification to realise improved outcomes for patients in relation to their health and wellbeing and service user experience whilst driving efficiencies and delivering innovation across the system.

Work with the Commissioner and the population of West Lancashire to communicate the right place to access the right care at the right time – demonstrating cohesion across the different parts of the service model and service providers.

Deliver financial requirements within the financial envelope and work with us to develop the financial model.

Actively engage with a wide range of people, their carers, the local community and other stakeholders on an on-going basis across the life of the contract to ensure that changing needs, outcomes and preferences are met. This will include demonstrating an understanding of and appropriately acting upon the needs of patients with chronic pain across West Lancashire.

The Supplier service will be expected to deliver the following:

- Improved health and health outcomes for the population of West Lancashire that suffer with Chronic Pain.
- High quality holistic care for patients that suffer with Chronic Pain.
- Reduced cost (delivering savings to the Commissioner) compared to the current cost of Pain treatment in West Lancashire (see the Excel files “Prescribing Data” and “Secondary Care Pain Management Data”).
- A single point of access for all chronic pain referrals to ensure that only appropriate referrals are forwarded to secondary care and most patients are managed and cared for within the community setting.
- Assess and manage patients within the service making use of alternative service providers which may include, but is not limited to, those provided by the voluntary, community and faith sector (VCFS) and local councils.
- Provide individuals with up-to -date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.
- Maximise and enable empowerment and self-care through education, self-management plans and current plus emerging technology where appropriate.
- Patients should be offered online access to their health records.
- Appropriate pathways should be designed for the main groups of patients, i.e. newly diagnosed chronic pain patients, those patients known to primary care with established chronic pain and patients that need further support after being discharged from the service for less than a year.
- If patients do need access to ongoing advice/treatments from the provider they can do so as part of a maintenance package of care on a self-referral basis for up to one year after discharge. This maintenance package of care should be

made up of an indicative number of follow ups. The maintenance package of care should also have a clear exit strategy from the service.

- Innovative use of current and emerging technology to drive the service in the way patients are managed, and to support patients to self-manage and take control of their care and health.
- Patients must be informed about the benefits and risks of conservative treatment measures, medication and surgery.
- Reduction in secondary care attendance for patients with chronic pain.
- Reduction in admissions to A&E for patients with chronic pain.
- Where patients are required to attend face to face appointments the service must:
    - Be provided in locations within the boundaries of West Lancashire.
    - Include co location with diagnostic services in line with NICE and local guidance on a one stop shop basis.
    - Be available in community locations commensurate with population need and patient choice.
    - Informed by equality impact assessment (EIA).
- Patients with chronic pain should be less dependent on health services and encouraged to self-manage their condition where possible.
- A holistic approach considering the patient, not just dealing with their pain symptoms.
- Seamless access to appropriate service/s including physical, emotional, social, economic, spiritual and technological interventions.
- Consider patient's response to pain and its effect on their ability to care for themselves.
- Use of a coaching approach, for example 'Better conversation' tools for action.
- Solution focused shared decision making (SFSDM).
- Interdisciplinary pain management approach, overseen by a specialist of the Supplier's pain management service.
- Evidence based interventions following national guidelines including recent NICE low back pain guidance, e.g. avoidance of back injections.
- Limb, joint and soft tissue injections should preferably be undertaken in Primary Care.
- Asset based approach with appropriate governance focusing on outcomes and cost effectiveness.
- The commissioner should be assured that WLCCG patients are achieving the best possible clinical outcomes by receiving the right treatment at the right time.
- Open and transparent performance monitoring shared with commissioners.

- A culture of continuing quality improvement informed by a comprehensive audit programme.
- Best value for money.
- Cost reductions in pain relief medication.

3. Scope

3.1 Aims and objectives of service

3.1.1 Clinical Outcomes

Prescribing

The Supplier will be responsible for any prescriptions including prescribing 'Red Drugs'. It may be appropriate for the service user to obtain some medications from their local pharmacy on advice from the Supplier. The Supplier would benefit from a good understanding of local Pharmacies in order to signpost suitable patients for a new medicine service (NMS) / medicines use review (MUR) as appropriate.

The Supplier should promote a step down regime to withdraw the drug from the patient or reduce to the lowest effective doses.

Where possible patients who can manage with over the counter medication or from interventions using a social prescribing approach such as a combination of services such as mindfulness, volunteering opportunities etc. should be encouraged to do so.

The supplier should promote a switch to the most cost effective medication in line with local guidance which will include the titration of medication.

The pharmacist(s) (or other suitably qualified clinicians) in the service will take a governance role and overview for reviewing the cost effective prescribing of medicines for nerve pain in line with local guidance.

Diagnostics

- It is expected that many diagnostics will have been initiated and the results collated in primary care prior to referral, the results being available to the service for patients referred to the Supplier. The Supplier should ensure they can access the results of diagnostic investigations that have been requested by primary care to avoid any duplication.
- The service should offer a full range of diagnostic services in line with NICE guidance for chronic pain where required while avoiding any duplication where investigations have already been carried out in Primary Care.
- Diagnostics should provide 24-hour turnaround of electronic reporting with results embedded into images. For the pilot phase diagnostic requests by the

Supplier will be treated as a “pass through” cost. For phase three onwards the costs may be incorporated in the service costs.

- The Supplier should utilise electronic requesting and reporting for all diagnostic tests.
- The Supplier should have access to Picture Archiving and Communication Systems (PACS) to access any diagnostic imaging already completed.

Psychological Support

- The Supplier should provide integrated access to psychological support as part of the patients care package as required.

3.1.2 Patient Experience

The service should deliver the best possible patient experience by providing:

- A convenient local service commensurate with population need, patient choice and informed by equality impact assessment.
- Pain managed in the community as far as possible.
- Single point of access.
- A seamless holistic service meeting patient’s needs.
- Timely follow ups meeting patient’s needs.
- Patients to be able to self-refer up to one year after discharge.
- Patient education and solution focused shared decision making so that everyone feels fully informed about their condition and treatment options.
    - Patients always know they have the option to cease treatment should they wish.
- A positive patient experience in a welcoming and friendly environment.
- High levels of patient satisfaction with >80% people recommending the service to family and friends.
- Levels of service ensuring low drop-out and DNA rates and increased patient compliance.
- The Supplier should also consider patient experience gathered by the Commissioner from chronic pain patients to date.

3.1.3 Value for Money

Excellent value for money through:

- Reduction in pain management prescribing.
- Cost reductions in pain relief medication.
- Cost reductions in Pain Management secondary care attendances.
- High quality procurement of alternative packages of care.

The overall principle will be to work in collaboration with successful Supplier(s) to ensure they design and then pilot the revised way of achieving the outcomes described, prior to entering into a 3 year contract (with an option for 2 further years).

The project will be split into the following 3 phases.

1. Design phase (phase1) lasting 3 months from procurement. The design phase will follow Pre Qualification Questions (PQQ) that will include questions on Supplier's technical and professional ability. There will be up to 2 providers in the design phase. Following the design phase one design will be selected to be used for the pilot phase.
2. The chosen design and the preferred bidder will progress to the pilot phase (phase 2) which will last for 2 years from the end of the design phase and will consist of one provider.
3. Delivery phase (phase 3) is to last up to 5 years following on from the pilot phase.

During phases 1 and 2 the CCG will aim to protect the preferred Supplier(s) from financial risk. From phase 3, it is expected that further risk may be transferred to the preferred Supplier at the Commissioner's reasonable discretion in agreement with the Supplier.

Estimated contract value/ budget available

Costings expressed at 2016/17 price base but with an adjustment to reflect the reduction in 2017/18 NHS national tariff price for chronic pain. Given that the service is new, these costings have been based on various assumptions which will crystallise somewhat during phase 1 and further during phase 2, the negotiation phases. They are currently therefore our best estimates based on information available and should be used to support the design of the service (see the iHELP Financial Envelope Excel file).

Anticipated Savings

There is an expectation that there will be total minimum savings per annum of £463,000 with effect from the pilot delivery stage of phase 2 (i.e. allowing a lower level of savings during the phase 2 mobilisation period). This expected savings per annum of £463,000 excludes the costs of alternative packages that the Commissioner will be responsible for during the pilot phase. Savings of below this annual level may be deemed indicative of a failure in the design of the system.

In terms of savings, as a minimum the Commissioner requires the aggregate cost of the new service (Supplier delivery team plus cost of alternative packages) to be less than the cost of treating those patients under the traditional model. Even that does not take account of the management resource which has been expended in procuring the new service, for which some return should be expected. The minimum level of savings identified of £463,000 would be expected to achieve this

requirement.

It should be noted also that any savings relating to the recent price decrease in Pregabalin will not be considered towards the target of £463,000.

Provision of Care

Budgets have been split between 'supplier delivery team' and 'alternative packages'. This distinction has been made to aid the Commissioner in modelling the case for change in Chronic Pain Treatment. Suppliers should treat the sum of these two budgets as the total funding available for provision of care. The Commissioner expects bidders to clarify what elements (and respective cost / activity levels) of provision will be delivered by the bidder and what elements of provision the bidder expects will be delivered by 3rd party organisations.

During phase 2, 3rd party provision of care will be funded directly by the Commissioner to help mitigate risk to bidders. It is expected that the successful bidder would reimburse 3rd party organisations for any care provided (including diagnostics) and recover these costs from the Commissioner as a pass-through payment.

For phase 3, the Commissioner will explore devolving 3rd party care budgets (including any diagnostics) to the successful bidder. It is anticipated there will be more certainty pertaining to 3rd party activity levels at this point and therefore less risk to the 3rd party care budget holder.

Flexing of budgets to reflect activity

The minimum savings projections are based on what we believe to be a minimum assumption of 35% of patients being deflected from acute care and 6% savings against primary care prescribing for pain management (excluding Pregabalin). These assumptions have also been used to estimate the cost of alternative packages of care for patients thus deflected. If, as is expected, a higher rate of deflections is achieved, this would mean greater savings accruing to the Commissioner and higher expenditure on alternative packages. The Commissioner would not wish to constrain the successful Supplier from making savings, consistent with clinical appropriateness, and so will increase the above budgets should actual levels of savings be higher than the minimum assumed.

It is expected that such flexing of budgets could result in a total budget over phases 1 to 3 (including the 2 year option) of up to £4,252,000.

If the service activity was lower than anticipated this could result in budgets being flexed down to a minimum over phases 1 to 3 (including the 2 year option) of £2,065,000, see the iHELP Financial Envelope spreadsheet.

Payments

Phase 1

For the preferred bidders:

- 50% of the Phase 1 tendered value will be guaranteed and paid upon submission of the interim written report in line with the design stage outputs described below.
- The remaining 50% of the Phase 1 tendered value will only be due if the final design phase outputs are assessed by the Commissioner as meeting all Phase 1 minimum requirements.

Note that at interim stage, the Commissioner will provide feedback to preferred bidders to support them in achieving all minimum requirements. However, preferred bidders should note that if they still fail to meet all minimum requirements the second 50% of tendered value will not be due to them.

Phase 2

From phase 2 onwards payments will be made on the first working day of each month in accordance with an agreed payment schedule. During phase 2 the monthly payments to the successful bidder will cover the successful bidder's cost of running the service and directly providing care.

It is expected that the successful bidder would reimburse 3rd party organisations for any care provided at the request of the Service (including diagnostics) and recover these costs from the Commissioner as a pass-through payment. The successful bidder will be able to recover these costs from the Commissioner each month through submitting an invoice to the Commissioner.

Phase 3

For phase 3, the CCG will explore devolving 3rd party care budgets (including any diagnostics) to the successful bidder. It is anticipated there will be more certainty pertaining to 3rd party activity levels at this point and therefore less risk to the 3rd party care budget holder.

Payments will either continue as in Phase 2 or be adapted to reflect any devolved budgets.

3.1.4 Technology

- Innovative use of appropriate technology for self-help and management.
- Innovative use of appropriate technology for recording and monitoring.
- Investigate the use of current and emerging technology to support patients, which may include but not be limited to Virtual Reality.

The Commissioner expects a service that not only achieves the above outcomes but also routinely and reliably demonstrates that they are being achieved.

3.1.5 Education

Clinicians

- Training to identify and refer suitable patients into the single point of access of the Supplier service.
- Collaborative pathway development.
- Feedback on referrals.
- Ongoing knowledge updates.

3.1.6 Asset Based Approach

The Supplier should foster an asset based approach to health that fits with the local social prescribing approach with full integration and possible subcontracting with appropriate services. Patients should be supported to access appropriate services during their care with the Supplier as well as after being discharged. The following list has been compiled with input from patients with chronic pain and offers insight into the services that may be helpful for patients:

- Exercise classes (with individual support as appropriate).
- Diet advice and help with methods of cooking that are easier to manage with limited Mobility/painful joints.
- Weight loss support.
- Physiotherapy.
- Hydrotherapy.
- Pilates or yoga with seated options available.
- Advice on managing specific conditions and information on local groups.
- Relaxation techniques and help with sleep disturbance.
- Medication reviews.
- Signposting to community activities - art, music, drama, volunteering.
- Counselling, anger management.
- Advice on using aids such as tens machine, pain relief pens, walking sticks, mobility scooters.
- Form filling and benefits advice.
- Information on alternative therapies.
- Discussion groups/expert patient sessions.
- Peer support.
- Breathing.
- Mindfulness.

- Leisure services.
- Support for patients experiencing social isolation.
- Group programmes and access to a wide range of external support groups for pain management.
- Employment support services that can help those patients whose pain affects their working life to remain in or return to work.

3.1.7 Technology (Patient Facing)

The use of current and emerging technology should be maximised to support patients for example, to enable self-help, pain control monitoring and to provide information to patients. The implementation of any new technology where evidence of its use is not substantiated in chronic pain management should be investigated in partnership with a suitable academic institution. Independent and impartial reviews of health and care related apps should be done by organisations such as Orcha that work in collaboration with the NHS (see https://www.orcha.co.uk/ for further information.

3.2 Service description/care pathway

The Supplier should offer support for patient's physical, psychological and social needs. It should ensure patients experiencing chronic pain are managed appropriately, which may include using third sector organisations such as, but not limited to, VCFS organisations, leisure providers and other appropriate sub contractors as far as safely possible.

Care pathways should consider:

- Existing patients already in receipt of care for pain management.
- New patients requiring pain management.
- A maintenance pathway for discharged patients.

The service must be developed to simultaneously pursue the three dimensions of the Institute of Healthcare improvement's "Triple Aim" approach, i.e.:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of the population.
- Reducing the per capita cost of health care.

3.3 Population covered

The service will be provided for residents aged 16 years and above that are registered with a GP practice within the geographical footprint of West Lancashire CCG.

3.4 Any acceptance and exclusion criteria and thresholds

All of the following criteria must be met:

- Referral from Primary Care Clinicians or Musculoskeletal Clinical Assessment Service.
- A diagnosis of chronic pain defined as pain that persists beyond the point at which healing would be expected to be complete (3-6 months) or that which occurs in disease processes in which healing does not take place.
- All investigations (in line with NICE guidance) completed by the referring Clinician to ensure diagnosis is of chronic non-malignant pain.
- Pain must be mainly somatic (physical feeling/experience) being present most of the time with varying intensity but not related to malignancy.
- Patients should be medically stable.

In addition to the above the patient may have one or all of the following:

- Pain which is causing significant distress or functional impairment.
- Analgesic misuse problems or who are taking recreational drugs/alcohol for pain relief - possibly in collaboration with addiction services.
- Pain-related psychological and psychosocial problems (e.g. pain related fear, anxiety, reactive depression, functional impairment) that complicate their pain symptoms or rehabilitation.

Exclusion Criteria

- Symptoms of acute pain.
- Known pathology requiring further investigation.
- Suspected cancer or cancer related pain
- Palliative pain.
- Post-operative or post traumatic complications.
- Suspected fracture/infection.
- Peri-natal back pain/pelvic pain.
- Chronic fatigue syndrome (unless their primary presenting symptom is chronic pain).
- Presence of red flags e.g. Cauda Equina Syndrome.

3.5 Interdependence with other services/providers

The Supplier should aim to offer an integrated model of service delivery and should utilise the skills of other external providers. Any contractual relationships established will be the responsibility of the Supplier. Below is a table highlighting some of the key relationships and how these could be utilised.

The Supplier should ensure it has an effective understanding of all the providers working within the chronic pain pathways and be able to establish operational links with each service to ensure smooth transfers of patients between services.

Supplier/Key Relationship	How Utilised
Primary Care	Working with Primary Care to ensure knowledge and understanding of the referral process, good quality of referrals, a good understanding of the service and how Primary Care can actively manage patients once discharged from the service. Provide appropriate levels of access to training and education including e-modules to referring clinicians. Provide regular updates to the CCG's GP membership (every 3 months). Work with Primary Care to establish support programmes within GP practice where it is safe to do so e.g. Pilates in the waiting room.
Joint Health Service	Establishing close relationships with the Joint Health services so that referrals into the Supplier service from Joint Health and vice versa are appropriate and timely. Ensuring patients understand their transfer of care. Joint Health is an Integrated MSK Service (Redesign of the Musculoskeletal Clinical Assessment Service (MCAS) and Routine Musculoskeletal Physiotherapy Service).
Secondary Care Pain Service providers	Establishing close links so that any specialist pain interventions needed (for patients not within the remit of the Supplier service) can be conducted quickly and effectively and choice of provider can be offered. Patients should be transferred back to the Supplier or primary care as soon as safely possible.
Independent Sector e.g. gyms	Establishing links with independent sector providers, working with them as part of a package of care to deliver parts of the pathway not within the capacity of the service e.g. access to gym equipment / swimming pools / hydrotherapy etc.
Local Authority e.g. leisure services / benefits	Establishing links with the Local Authority working with them as part of a package of care to deliver parts of the pathway not within the capacity of the service e.g. access to gym equipment / swimming / hydrotherapy pools and utilising the range of services Local Authorities have at their disposal e.g. benefits advice etc.
Employment advice services	Establishing links with benefits / employment agencies to ensure pain is not a barrier to returning to or finding employment.
External pain / patient support groups	Develop an asset based approach to health with full integration and possible subcontracting with appropriate support groups which may include voluntary community and faith sector organisations, peer support, Pilates, yoga, breathing and mindfulness etc.

The above list is neither prescriptive nor exhaustive.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following national standards have been used in the design of this document and must be complied with by the Supplier:

- NICE (November 2016) Low back pain and sciatica in over 16s: assessment and management.
- Core Standards for Pain Management Services in the UK (2015) Faculty of Pain Medicine of the Royal College of Anaesthetists.
- The British Pain Society and Royal College of General Practitioners (2013) Implementing the British Pain Society Pain Patient Pathways and Preparing for the Commissioning Agenda (supporting document).
- Department of Health (2010) Essence of Care 2010 Benchmarks for the Prevention and Management of Pain.
- NICE (2010) Neuropathic Pain – The Pharmacological management of neuropathic pain in adults of non-specialist settings.
- Department of Health (2009) 18-week Commissioning Pathway for Chronic Pain.
- NICE (2009) Low back pain: early management of persistent non-specific low back pain. Full guideline. London (UK): May. 240 p. (Clinical guideline; no. 88).

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

- The British Pain Society and Royal College of General Practitioners (2008) A case of neuropathic pain.
- Map of Medicines pathways.

4.3 Applicable local standards

- The service should be CQC registered with no conditions.
- The service will share information with commissioners to support quality improvements (subject to IG rules).
- The service will actively collect analyse and act on feedback from patients and carers.
- The service will participate in clinical audit cycles and external peer review.
- The service will signpost patients to local services which could help them.
- Information and services will be available for individuals who are able to self-manage their conditions or who need care plan support.

- The Supplier should actively work with other providers to increase the efficacy of the new service (e.g. third sector, schools, libraries, religious organisations, social services).

- The Supplier should demonstrate that they have identified any potentially hard to reach groups (as defined by the Joint Strategic Needs Assessment (JSNA)) that exist within their target population, and have taken appropriate action to improve access to the service for these groups.
- The Supplier should offer robust evidence based procedural interventions such as injections. The Supplier should not offer Acupuncture, Transcutaneous Electrical Nerve Simulation (TENS) or therapeutic ultrasound for managing low back pain with or without sciatica as specified in the 2016 NICE guidance for lower back pain.

4.4 Qualifications and Mandatory Training

The Service must adhere to the Terms and Conditions and the General Conditions of the NHS Standard Contract.

All staff must be appointed in line with professional qualifications / standards as appropriate and continue to update skills in line with professional codes of conduct. The Supplier must maintain a record of the dates and training given to all clinicians and staff working within the service. All such records should be immediately available to the Commissioner for audit purposes on request. The Supplier must ensure that training requirements and competencies are monitored through regular assessment and staff appraisal and that staff are enabled to progress through supported learning.

No healthcare professional shall perform any clinical service unless he / she have such clinical experience and training as are necessary to enable him / her properly to perform such services. The Supplier shall be responsible for ensuring that their staff:

- Have relevant professional registration and enhanced checks undertaken prior to seeing patients alone.
- Have, prior to starting in post, provided two references (clinical if applicable), relating to two recent posts (which may include any current post) as a health care professional which lasted for three months without a significant break, or where this is not possible a full explanation and alternative referees.
- All access robust induction training applicable to their individual role.
- Have access to and evidence of safeguarding training and development in line with their professional bodies recommendations.
- Undertake annual audit to ensure compliance with the above.

4.5 Workforce requirements

The Supplier must have in place a comprehensive, coherent, robust plan for recruitment, management and development of staff with the principle objectives to:

- Meet the essential day to day staff leadership, management and supervisory needs to the contract during its lifetime, including during mobilisation and, if appropriate, contract termination.
- Adhere to TUPE legislation (as applicable).
- Support the provision of safe, high quality clinical services.
- Ensure through appropriate audit, training and continuous professional development that all staff involved in treating NHS patients are and remain qualified and competent to do so.
- Support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice.
- Maintain an effective working partnership with local NHS employers to continuously develop and maintain best people management practices and ways of working.
- Reduce dependency on agency or locum staff to deliver services, such use not to exceed 10% unless in extreme circumstances.

The Supplier must have in place a recruitment and retention strategy. This must:

- Can attract and retaining high quality job applicants.
- Optimise individual skill levels and potential.
- Fully harness available skills and commitment.
- Encourage and engender support for new ways of working.

There are continual challenges to the UK's viability to opt out of the Working Time Directive on a European basis and therefore to sustain the future viability of this service the Supplier must have in place a working hour's policy which ensures the health and wellbeing of staff and users of the service. This policy must also cover the working hours of clinical staff outside of the service, and in particular, the Supplier must ensure they have a mechanism in place which supports them in reviewing and monitoring the hours worked by clinical staff and assuring themselves that the service they provide is safe. The Supplier must have in place a staffing strategy to meet specified levels of service that identifies the requirements for support ancillary staff services. The strategy should include contingency plans for times of high demand and/or high levels of staff absence. The Supplier must have in place mechanisms for keeping the commissioner informed when staffing capacity is unlikely to meet demand and the actions that will be taken to address this. It is expected that the Supplier will have in place mechanisms to actively review and monitor the working hours of all staff members. The Commissioners reserve the right to carry out unannounced audits to assess compliance.

4.6 Workforce standards

The Supplier must ensure that all proposed workforce strategies, policies, processes and practices comply with all relevant employment legislation applicable in the UK.

In addition, the Supplier is required to comply with the provisions of the following policies and guidance as amended from time to time:

- NHS Employment Check Standards, March 2008 (revised July 2010).
- Registration with Care Quality Commission (http://www.cqc.org.uk/).
- Criminal Records Bureau Code of Practice and Explanatory Guide for Registered Persons and other recipients of Disclosure Information published by the Home Office under the Police Act 1997 (revised April 2009) ("Code of Practice on Disclosure").
- The Department of Health (DH) guidance on the employment or engagement of bank staff, if any.
- Any guidance and/or checks required by the Independent Safeguarding Authority or any other checks which are to be undertaken in accordance with current and future national guidelines and policies.
- All guidance issued by the Care Quality Commission including the guidance entitled "Compliance: Essential Standards of Quality and Safety (March 2010)" and any other guidance issued by the Care Quality Commission from time to time.
- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf.
- The Cabinet Office Statement entitled "Principles of Good Employment Practice (December 2010)".
- All relevant employment legislation and codes of practice applicable in the UK.

The Supplier has the following responsibilities in line with the delivery of this service:

- To ensure that all members of the service maintain their knowledge and skills by keeping up to date, attending meetings and participation in in-house academic sessions. This requirement would be assessed during an annual appraisal.
- To provide clinical education to practices within the locality to support further development of their knowledge and skills in the on-going management of patients.
- To ensure that all professional staff are supported to undertake clinical supervision in line with the relevant statutory body requirements.

4.7 Equipment

It is the responsibility of the provider to purchase, maintain to a high standard and replace all relevant equipment required to provide the service. The Commissioner will expect a detailed plan for both the commissioning and maintenance of all equipment and clear accountability for making sure its implementation.

4.8 Information Management & Technology (IM&T)

The Commissioner requires the Supplier to use EMIS Community Web or an equivalent system to deliver the service as utilised across primary/community care in the local health economy. If, however the service provider does not use EMIS Community Web, it is the responsibility of the provider to ensure that their clinical

system is fully interoperable with EMIS Community Web and shared patient records should be available between the Supplier and General Practice. Any costs for achieving interoperability should be borne by Supplier.

The Supplier will be responsible for the provision, maintenance and cost of all Information Management & Technology (IM&T) hardware and software, licenses and IT support services required to meet the needs of the service. These will need to meet local and national standards and support the Commissioner's direction of travel regarding interoperability. The Supplier must ensure that appropriate "IM&T Systems" are in place to support the service prior to the go-live date. "IM&T Systems" means all computer hardware, software, networking, training, support and maintenance necessary to support and ensure effective delivery of the service, management of patient care, contract management and of the organisation's business processes, which must include:

- Clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports.
- Prescribing.
- A single electronic patient health record for every patient, which should include the patient's NHS Number.
- Inter-communication or integration between clinical and administrative systems for use of patient demographics.
- Use of the NHS e-Referral Service (e-RS) (or any future replacement) and systems for referral management and booking for both Primary Care referrals to the Supplier and onward referral from the service to a specialist.

The Supplier must use appropriate technologies for Managing call traffic to the service:

- Main telephone system (PABX).
- Automated call distribution (ACD).
- Interactive voice response (IVR).
- Customer announcements.
- Call recording.
- Dealing with calls.

The Supplier must use appropriate technologies for Managing contact to the service and information within the service:

- Customer contact management.
- Scripting.
- Case-based reasoning.
- Resolving enquiries.
- Applications systems.
- Intranets.
- Workflow.
- Document image processing.

- Geographic information systems.

The Supplier will need to ensure that IM&T Systems are effective for referrals and bookings including appointment booking, scheduling, tracking, management and the onward referral of patients for further specialised care provided by the NHS, independent sector or social care and must be compliant with the NHS e-RS requirements including the use of smart cards. The appropriate security, information management and technology should be in place to support the services.

The following systems should be in place and comply with NHS requirements:

- NHS e- Referral System: use of the Directly Bookable Service (DBS) for all patient referrals into the service.
- N3: use of the national network for all external system connections to enable communication and facilitate the flow of patient information.
- Patient Demographic Service (PDS): use of the PDS to obtain and verify NHS Numbers for patients and ensure their use in all clinical communications.
- NHSMail: use of the NHSMail email service for all email communications concerning patient-identifiable information or the appropriate local solution.
- The Supplier must undertake testing of the IM&T Systems proposed, including those supplied by the Commissioner, by the Supplier, by third party suppliers and also of any interfaces and inter-working arrangements between parties or systems, so as to guarantee compliance with all appropriate standards.

The Supplier must ensure that the IM&T Systems and processes comply with statutory obligations for the management and operation of IM&T within the NHS, including:

- Common law duty of confidence.
- Data Protection Act 1998.
- Access to Health Records Act 1990.
- Freedom of Information Act 2000.
- Computer Misuse Act 1990.
- Health and Social Care Act 2001.
- UK Medical Devices Regulations 2002 (as amended) unless the potential Supplier can demonstrate an exemption.

The Supplier must be compliant with national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

- NHS Confidentiality Code of Practice.
- Use of the Caldicott principles and guidelines.
- Appointment of a Caldicott Guardian.
- Policies on security and confidentiality of patient information.
- Clinical governance in line with the NHS Information Governance Toolkit.
- Risk and incident management system.

- Information Governance Statement of Compliance (IGSoC).

4.9 Referral Process

- Referrals into the service will be via patient's GP practice and the Musculoskeletal Clinical Assessment Service (Joint Health).
- Referrals will be received into the service via the NHS e-Referral Service (e-RS).
- All referrals should be triaged daily via the NHS e-RS, referring patients on to other services as appropriate.
- Text reminders to patients about their appointment should be sent to consenting patients that have a mobile phone contact number.
- The Supplier is responsible for the booking of interpreters when this requirement is stated within the referral letter or indicated via the NHS e-RS.
- The Supplier should process Did Not Attend (DNA) events via the NHS e-RS in order that the referrer has access to this information via the e-RS Worklist facility.
- The Supplier should process discharge information back to the practice within two working days of the patient being discharged from the service. The process of forwarding discharge information back to the referring practice should be electronic.
- The Supplier will provide access to Advice and Guidance for referrers via the NHS e-RS with a turnaround of no more than two working days for all Advice and Guidance requests.
- The Supplier must setup their service as an assessment service on the NHS e-RS. There are two types of assessment service available on the e-RS:
    - Clinical Assessment Service (CAS)
    - Telephone Assessment Service (TAS)
- If the CAS setup is used patients must be able to attend the appointment to progress their referral. If the TAS setup is used patients must be able to telephone the service or be telephoned on the date and time of the appointment they are given to progress their referral.
- Referrals must be submitted by General Practices to the Supplier via the NHS e-RS. Any referrals from General Practice that are not submitted via the NHS e-RS should followed up and the referring practice supported to enable future referrals to be submitted by the e-RS. Referrals from Joint Health should be submitted via the NHS e-RS and followed up if not to ensure all future referrals are submitted via the e-RS.
- All referrals should be triaged by appropriately qualified staff to assess appropriateness and decide the onward pathway for each referral. The outcome of the triage should be recorded on the e-RS to allow the referrer to see the outcome. Also, any referrals to first outpatient consultant lead services should be referred on via the e-RS as well as any other services that are available on e-RS such as Joint Health.
- Patients should be given a choice of where they would prefer to be seen and an appointment or appointment request should be created with the details given to the patient.
- The referral must undergo the initial triage by the Supplier within two days from receipt of referral.

- The Supplier will provide appropriate clinical and onward referral information adhering to the NHS Choice Framework as appropriate.

4.10 Discharge Processes

Patients should be discharged with a clear management plan supported by appropriate use of technology, e.g. a personalised video for exercises. This management plan should include clear information on how to self-manage their condition, how to access free/low cost services in the community and how to gain future access to the service, as appropriate. A key outcome of the service is to reduce reliance on health service resources where appropriate, and empower patients to manage their condition. However, if patients do need access to ongoing advice/treatments from the provider they can do so as part of a maintenance package of care on a self-referral basis for up to one year after discharge. This maintenance package of care should be made up of an indicative number of follow ups. The maintenance package of care should also have a clear exit strategy from the service. Keeping GPs informed about the discharge process and patient management plans is essential. The Supplier should provide clinical information on discharge from the service to the patients GP and Patients will receive an electronic or written copy of their discharge letter from the service. GPs will need to be sent discharge information and key information about their patient's management plan within two working days electronically.

Acceptable discharge criteria are as follows:

- Resolved.
- Optimum outcome following treatment or advice achieved.
- Patient able to self-manage.
- Patient able to manage condition with exercise programme or third sector activity.
- Patient failed to attend for initial appointment or full course of treatment in line with the DNA policy agreed with the commissioner.
- Patient declines to participate in recommended evidence based management.
- Patient requires referral to another discipline or back to original referrer.
- Discharge back to GP for further management with advice.

Information provided to a patient's GP at discharge should include:

- Patient identifiable details (patient NHS number / name).
- Date of attendance and discharge.
- Investigations carried out with the results and appropriate advice.
- Summary of findings (including diagnosis).
- Information provided to the patient.
- Management plan.
- Medications initiated or terminated.
- Follow-up arrangements.

4.11 Response Times and Prioritisation

- Patients requiring face to face contact should be seen by the service within four weeks of referral.
- Same day telephone advice should be available for Primary Care Clinicians including out of hours and Extended hours GPs, for patients with urgent needs e.g. who are failing to cope, in order to prevent A&E attendance or secondary care admission.
- Patient's referred as urgent or triaged and updated to being urgent by the service should be seen within seven days.

Social support for patients not coping, e.g. provided by the various providers, such as but not limited to VCFS, should be agreed between patient and the service provider to be within appropriate time frames to provide the necessary support in order to prevent A&E or secondary care attendance.