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| **Continence Service**  **Implementation Pack** |

**Preface**

**Introduction**

This implementation pack has been designed to support commissioners to deliver Any Qualified Provider in Continence locally. It has been developed by NHS commissioners, clinical experts and DH officials, working in partnership. The use of this pack is not mandatory. Commissioners can refine it to meet local needs and, over time, help to improve it. The pack is simply a place to start, avoiding duplicating effort.

This pack should be used for services that are commissioned using the Any Qualified Provider (AQP) model – where commissioners are aiming to secure innovation or deliver more choice for patients for example. Other forms of procurement are also available, which might suit other circumstances, more details of these can be found in DH procurement guidance.

The AQP impact assessment shows that the cost of procuring services per project under AQP is lower than existing arrangements:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_128457>

This pack has been prepared by working with a range of professionals, from both clinical and commissioning backgrounds and we recommend that commissioners using these packs continue to engage with clinicians, professionals and a wide range of providers wherever possible.

Generally we expect there to be consistency across service specifications to sustain quality and help to spread best practice, but where necessary specifications should be amended to reflect local variations in need.

More information and further resources for commissioners can be found here: <http://nww.supply2health.nhs.uk/AQPRESOURCECENTRE/Pages/AQPHome.aspx>, including a pricing principles document that should be read alongside this implementation pack.

If commissioners do come up with innovative new ways to drive up the quality of care by offering choice of provider - please use the AQP resource forum to share your hard work.

**Workforce, education and training implications**

When commissioning a service under patient choice of AQP, there are some important workforce, education and training considerations, which commissioners must take into consideration. Annex 2provides some additional details on these issues.

**Public Sector Equality Duty**

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. Please refer to Annex 3: Public Sector Equality Duty and visit the Department of Health website for more information on 'Equality and Diversity'.

**Glossary**

A glossary of terms used within this implementation pack is included in Annex 4.

**Next Steps**

These packs will be used by commissioners undertaking AQP in Adult Hearing through 2012/13. An evaluation of the pack and the AQP process will be undertaken during this period. In the meantime if you have any questions or comments on this pack, please contact [AQP.Queries@dh.gsi.gov.uk](mailto:AQP.Queries@dh.gsi.gov.uk)

**Document Management**

**Document Control**

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**Forward**

In July, the DH published guidance to support the phased expansion of Patient Choice of Any Qualified Provider to community and some mental health services.

To support the NHS volunteer PCT clusters were identified to work with emerging CCGs and the DH to co-produce the development of an implementation pack for a selection of services. The production of the pack was supported by DH and required the cluster to work with patient groups (both locally and from service / patient representative organisations), providers, regulatory bodies, clinical professionals and other interested commissioners to prepare a pack that is tested and suitable for sharing for use by other NHS commissioners.

The implementation pack for Continence has been developed by Cheshire, Warrington and Wirral NHS.

# 

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## SERVICE SPECIFICATION

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.

Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

|  |  |
| --- | --- |
| Service Specification No. | AQP |
| Service | Community Integrated Bladder/Bowel Service (adults and children) |
| Commissioner Lead | CCGs |
| Provider Lead |  |
| Period |  |
| Date of Review |  |

### Population Needs

#### National/ local context and evidence base

##### Adults

* Urinary incontinence (UI) affects 1 in 3 women aged 18+ (35,000:100,000 women), but less than 20% are actively treated
* Lower urinary tract symptoms (LUTS) affect 2.7% of men aged 18+ and 35% of men aged 60+
* UI and / or faecal incontinence affect 50-80% of care home residents

For a standard population of 250,000, assuming that around 40% are women aged 15 years or older (100,000), the average number of women requiring referral into a bladder and bowel dysfunction service would be 800 per year (0.80% of the female population).

For an average practice with a list size of 10,000, assuming that around 40% are women aged 15 years or older (4000), the average number of women requiring referral into a bladder and bowel dysfunction service would be 32 per year (0.80% of the female population). [[1]](#footnote-2)

* Faecal incontinence (FI) is a stigmatising condition that is likely to affect over half a million men and women in the UK. Epidemiological information shows that between 1% and 10% of adults are affected.
* It is likely that 0.5–1.0% of adults experience regular FI that affects their quality of life. FI is closely associated with age (prevalence is about 15% in adults aged 85 years living at home) and is even more common in residential and nursing homes (prevalence ranges from 10% to 60%).

Conservative management/treatment for urinary/faecal incontinence is recommended to include lifestyle, physical, behavioural and drug therapy interventions. 1,[[2]](#footnote-3)

Graph 1: Projected Impact of incontinence in people over 65 yrs 2008-2033

The graph shows levels of continence problems among those aged 65+, for an average practice with a list size of 10,000, living in the community according to the highest and lowest predictions.

As examples

* The highest estimate for men is 2430 rising to 3620 by 2033
* For women the highest estimate is 6760 (2008) predicted to rise to 9440 by 2033

##### National Guidance

* The 2001 National Service Framework for older people called for the establishment of integrated continence services for older people.

<http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004832>

* Essence of Care 2010 Benchmarks for Bladder ,Bowel and Continence Care

<http://www.tsoshop.co.uk/bookstore.asp?FO=1161150&DI=627604>

* Urinary continence service for conservative management of urinary continence commissioning guides 2008.

<http://www.nice.org.uk/media/879/50/UrinaryIncontinenceCommissioningGuide.pdf>

* NICE guidance for Female incontinence 2006

<http://www.nice.org.uk/nicemedia/live/10996/30282/30282.pdf>

* NICE guidance for Faecal Incontinence 2007

<http://www.nice.org.uk/CG49>

* Cost effective commissioning for continence care - all Party Parliamentary Group For Continence Care Report 2011

<http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf>

* National Audit of Continence Care Combined Organisational and Clinical Report
* September 2010 Commissioned by The Healthcare Quality Improvement Partnership. Conducted by:
* Clinical Standards Department, Royal College of Physicians, London

<http://www.rcplondon.ac.uk/sites/default/files/full-organisational-and-clinical-report-nacc-2010.pdf>

##### Children

The National Service Framework for children, young people and maternity services (standard 6) states that, “There are at least 500,000 children in the UK who suffer from nocturnal enuresis (persistent bedwetting) and a significant number with daytime wetting and faecal incontinence, yet services are currently fragmented and often made up of a collection of professionals providing different levels of intervention in both the community and hospital.” This results in the inappropriate use of resources.

**References**

* National Service Framework for Children and Young People and Maternity Services: Children and Young People who are Ill: Standard 6, Department of Health, 2007.

<http://www.dh.gov.uk/en/Publicationsandstatistics/Pulications/PublicationsPolicyAndGuidance/DH_4089114> (report from 2004)

* National guidelines (e.g. ‘Good practice in continence services’ guide) relating to childhood continence advocate a community based nurse led continence service. DH (2000) Good Practice in Continence Care

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

As an example, activity data (PbR 09/10) from Wirral, provides the following detail, for population of 320,000.

| Paediatric (new) | Paediatric (follow up) |
| --- | --- |
| 252 | 1076 |

##### National guidance

* NSF for Children, Young People and Maternity Services (Standard 6, 2007).

[www.dh.gov.uk/en/Publicationsandstatistics/.../DH\_4094336](http://www.dh.gov.uk/en/Publicationsandstatistics/.../DH_4094336)

* NSF for Children, Young People and Maternity Services, Continence issues for a child with learning difficulties (September 2010).

[www.dh.gov.uk/en/Publicationsandstatistics/.../DH\_119304](http://www.dh.gov.uk/en/Publicationsandstatistics/.../DH_119304)

* Good Practice in Continence Services (Department of Health, 2000).

[www.dh.gov.uk/en/Publicationsandstatistics/.../DH\_4005851](http://www.dh.gov.uk/en/Publicationsandstatistics/.../DH_4005851)

* Good Practice in Paediatric Continence Services (Benchmarking in action, 2003).
* NICE Commissioning Guide – Paediatric Continence Services – implementing NICE guidance 2010

<http://www.nice.org.uk/media/12D/BD/PaediatricContinenceCommissioningGuide.pdf>

* NICE Guidelines: Nocturnal Enuresis (bedwetting) in children (Published October 2010) and Constipation in Children (Published May 2010).

[www.nice.org.uk/nicemedia/live/13246/51367/51367.pdf](http://www.nice.org.uk/nicemedia/live/13246/51367/51367.pdf)

* QoL tools for children: PinQ: a valid, reliable and reproducible quality-of-life measure in children with bladder dysfunction. Bower WF, Sit FK, Bluyssen N, Wong EM, Yeung CK.
* J Pediatr Urol. 2006 Jun;2(3):185-9 and Development of a validated quality of life tool specific to children with bladder dysfunction. Bower WF, Wong EM, Yeung CK. Neurourol
* Urodyn. 2006;25(3):221-7.

##### Delivering Outcomes

The logic model (Theory Approach Logic Model [W. K. Kellogg Foundation, 2001]) supports the outcome based element of this specification focusing on the inputs through to impact.

Table 1: Logic model

|  |  |  |
| --- | --- | --- |
|  | Activity | Measure |
| Impact | Number of adults and children self-managing  Reduction in avoidable secondary care attendance, admission  Reduction in UTIs  Reduction in unnecessary treatment and inappropriate reliance on products for the containment of urinary/faecal incontinence | Questionnaire at 9 months (may be conducted by telephone)  Difference from baseline data (commissioner responsibility)  Difference from baseline data (commissioner responsibility)  Difference from baseline data (commissioner responsibility) |
| Outcome | Number of adults and children cured, treated or symptoms alleviated whilst within the service or post discharge | Repeat symptom questionnaire at 6 and 9 months (may be conducted by telephone) |
| Outputs | Number of adults and children referred to, triaged and treated within the service | Patient experience of the service and quality questionnaire  Individualised management plan |
| Intervention | Adult or child care pathway as per activity data collected | Intervention data collected (see activity plan) |
| Inputs | Person or child with bladder/bowel dysfunction | Base line symptom and quality of life questionnaire completed |

<http://www.evaluationtoolsforracialequity.org/evaluation/tool/doc/pub3669.pdf>

### Scope

#### Aims and objectives of service

##### Service Objectives

* Care closer to home
* Maximum wait time of 28 calendar days for continence appointments
* Flexibility within the service to provide appointments to support more urgent demand or unplanned care
* Individualised care bundles (treatment) with management plans for all patients
* Reducing unnecessary treatment and inappropriate reliance on products for the containment of urinary/faecal incontinence
* Providing the best possible outcomes for women, men and their carers through identification and intervention, resulting in alleviation of symptoms and/or cure
* Providing the best possible outcomes for children and their carers through treatment, management and intervention, resulting in alleviation of symptoms and/or cure
* Reducing the risk of catheter associated urinary tract infections, by providing access for routine catheter change to provide closer to home care for ambulant patients who do not meet the criteria for community nursing services. Note best practice for use of indwelling catheters.
* Discharge communication to GPs
* Reducing inequalities and improving 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 bladder and bowel dysfunction services through appropriate information leaflets
* Staff to be trained to the appropriate level in terms of safeguarding children and young people.
* An integrated service which can positively contribute to, the local health care community and colleagues from social care (including the Children and Young People’s Department)
* Provide relevant training to social care services, care home staff, GPs, practice nurses, community and hospital nurses, health visitors

##### Adults – 18 years and over

Aim to deliver a community bladder/bowel dysfunction service for patients with or without incontinence in order to provide effective and efficient clinical care/conservative management and treatment

* To include relevant signposting
* To include referral triage
* To include quality of life and symptom profile questionnaires
* To include face to face standard assessment with relevant investigations
* To provide a nurse led community based model, with assessment and investigation where appropriate, thereby reducing inappropriate/unnecessary referral to secondary care
* To include patient information leaflets and lifestyle support
* To develop and mutually agree an appropriate management and treatment plan utilising the Map of Medicine pathways
* To promote and support the development of self care
* To include assessment for appropriate containment products
* To include access to routine catheter change appointments as appropriate
* To include appropriate follow up
* To include communication to referring clinician and patients own GP after first consultation and on discharge

##### Children

**Aims:**

To provide a service for children and young people aged 0 (0 -2years on agreement by paediatric continence nurse) to 19 with bladder and bowel dysfunction.

* To provide a nurse led community based model, with assessment and investigation where appropriate, thereby reducing inappropriate / unnecessary referral to secondary care
* To develop and mutually agree an appropriate management and treatment plan utilising the Map of Medicine pathways with parent/guardian
* To provide a holistic approach to care for children and young people, including containment products and management options.
* To offer an advisory and clinical service to patients, parents/guardians, relevant health care professionals, education services and others as appropriate.
* To include communication to referring clinician and patients own GP after first consultation and on discharge

##### Transition

**Aims:**

To integrate with the adult element of the service to facilitate smooth transition from children’s to adult’s services to include young people aged 16-18, newly referred into the service.

* The National Service Framework (NSF) for children and young people states that, “Well planned transition improves clinical, educational and social outcomes for young people…Successful transition planning and programmes are crucially dependent on collaboration between children’s and adult services.”
* The provider must work to the following guidelines for the transition of young people to adults services:
* NSF for Children, Young People and Maternity Services – Transition: getting it right for young people, 2006. Department of Health/Child Health and Maternity Services Branch, 2006 <http://www.dh.gov.uk/en/Pulicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4132145>

#### Service description/ care pathway

##### Adults

Service staff through provision of education and training to other health care professionals will aim to encourage the active identification of people with bladder and bowel dysfunction and improve awareness of the community service.

The service must provide triage daily Monday to Friday within 24 hours of receipt and provide an initial assessment for all new patients referred and accepted into the service.

The provider must ensure there are 2 ways to refer into the service, GP/health care professional referral and patient self-referral (direct access). People experiencing problems who wish to self-refer should ring the service in order to speak to a clinical member of staff to complete the generic referral form, symptom profile questionnaire and quality of life questionnaire. The provider must request that the GPs provide a medication list and past medical history for patients who self-refer, where appropriate and the patient consents, within 3 working days of the request.

##### Triage

Separate generic referral forms, male and female must be completed in full by the referring clinician in order to support triage to the most appropriate assessment and treatment pathway, these being:

* If triage indicates cancer specific, red flags etc refer direct to urologist or colorectal surgeon or gynaecologist within secondary care within 24 hours as not appropriate for this service

If accepted into the service patient to receive either:

* A Level 1 appointment with a nurse or physiotherapist (within 28 calendar days), or
* A Level 2 appointment with a specialist nurse (continence, urogynae, urology) or specialist physiotherapist (within 28 calendar days)

Please refer to page 23 for definitions of level 1 and level 2 appointments

**References:**

CG 40 Urinary Continence: Nice Guideline (<http://www.nice.org.uk/CG40>)

CG 49 Faecal Continence: Nice Guideline (<http://www.nice.org.uk/CG49>)

Incomplete referral forms must be returned to the referrer by the provider for the missing information.

Examples of referral forms can be found here:



Please see examples of Map of Medicine pathways embedded here, local variation may apply.

**Female Urinary Incontinence**



**Male Incontinence**



The provider must ensure that conservative management/treatment for bladder dysfunction includes (but not exhaustive)

* Lifestyle interventions.
* Pelvic floor muscle training.
* Bladder training.
* Drug treatment if bladder training is ineffective.
* Bladder catheterisation (intermittent self-catheterisation) for patients in whom persistent urinary retention or lower urinary tract symptoms exist.
* Advanced pelvic floor muscle rehabilitation including electrical stimulation (neuro-stimulation, neuro-modulation), manual therapy techniques (such as trigger point techniques, connective tissue massage and biofeedback therapy

As initial treatment options as per NICE guidance.

**Reference:**

CG 40 Urinary Continence: Nice Guideline (<http://www.nice.org.uk/CG40>)

Conservative management/treatment for bowel dysfunction includes (but not exhaustive)

* Addressing reversible factors using a conservative approach that includes advice about diet, bowel habit and/or medication.
* The specialised management of bowel dysfunction includes non-surgical interventions such as pelvic floor and anal sphincter muscle training, defaecatory retraining, specialist dietary advice, biofeedback, (including rectal balloon expulsion training) electrical stimulation and rectal irrigation.
* Only if this fails to restore continence does it progress to specialised options and investigations i.e. for constipation/soiling, rectal damage, and neurological bowel through pathways for referral to colorectal

As initial treatment options as per NICE guidance.

**Reference:**

CG 49 Faecal Continence: Nice Guideline (<http://www.nice.org.uk/CG49>)

Competencies for specialist treatment and bowel management, in particular irrigation and electrical stimulation and/or biofeedback must be achieved by relevant clinical staff and monitored by the service lead with reference to the competency skills framework.

Figure 1: Service Pathway

Accepted patients, following triage and having met the inclusion criteria will be offered a level 1 or 2 appointment within 28 days and on receipt of referral all patients will be sent a quality of life questionnaire, a symptom profile questionnaire and either a frequency and volume chart or 3 day bladder diary. Provider must provide appropriate healthcare assistance to patients asking for help in completing the questionnaire within 10 days from request either face to face or telephone based on need. Where identified through the triage process the patient may require assistance in completing forms e.g. visually impaired, the provider must offer assistance.

Examples of quality of life questionnaire, symptom profile and a frequency and volume chart/ 3 day bladder diary can be seen here:



Appointment decision for either level 1 or 2 will be based on the triage assessment (undertaken by a senior/specialist clinician in continence care) of clinical indicators and complexity of presenting symptoms

All patients will be asked to bring the completed questionnaires to their initial assessment. This supports diagnostic capability and will support shared decision making at the first appointment. The provider must ensure that initial appointments will generally be in the clinic setting but may be at home if identified on the referral form i.e. housebound\* patients.

##### Housebound patients criteria

* Those who are so elderly and frail or infirm that it prevents them leaving the house
* Those with severe physical disability that it prevents them leaving the house
* Those with certain mental health problems which make it difficult to leave the home
* Those with sensory disabilities especially severe visual impairment
* Those with profound or severe learning difficulties

##### Level 1 appointment provided within the service

Basic holistic assessment undertaken by knowledgeable and competent practitioner who has relevant training e.g. accredited module for urology. This appointment will include development of a personalised management/treatment plan and education regarding application and correct use of appliances to patients, carers and other relevant health care professionals. This may include catheter changes where required/appropriate.

##### Level 2 appointment provided within the service

Assessment for complex presenting symptoms undertaken by a specialist nurse (continence, urogynae, urology) or specialist physiotherapist (women’s health or continence rehabilitation) with relevant specialist qualification e.g. BSc or equivalent and a minimum of two years’ experience in the field of continence and independent prescribing qualification desirable. This will include development of a personalised management/treatment plan and education utilising enhanced skills in relation to muscle function and to conduct prostate and prolapse examinations and prescribe where required and appropriate.

##### Initial Level 1 and 2 appointments will take approximately 1 hour and may include

* Assessment and examination to include vaginal/rectal examination
* For level 2 assessments, prostate and prolapse examinations
* Portable bladder scan
* Portable uroflometry as appropriate
* Health promotion and lifestyle advice, information leaflets, self care booklets
* Development of management and treatment plan, patient ownership
* Initiation of appropriate treatment
* Referral to other services as appropriate
* Prescription for containment products/medication
* Patients will be assessed and provided with mechanism (locally defined) for daily pads (disposable/reusable containment products)
* Decision regarding follow up (subsequent 1/2 hour review(s))
* Communication to GP after first consultation within 3 working days

Patient follow up if required (15 -30 mins depending on complexity) will be Map of Medicine pathway specific (max number of 6 visits within the patient pathway and determined by clinical need) and will include:

* Intermittent self-catheterisation
* Bladder drill
* Ambulant catheter patients
* Rectal irrigation (complex bowel management for spinal injury, multiple sclerosis)
* Advanced rehabilitation techniques
* Medication review

Complex adults would benefit from joint consultation which should be arranged with multidisciplinary input across secondary, tertiary, community care, where appropriate

Patient’s dignity should be maintained at all times, this may be by choice of male/female staff

Patients who Do Not Attend (DNA) on more than two occasions must be discharged from the service and their GP informed.

The provider must negotiate with the referring GP in cases where a patient requires more than 6 follow up appointments.

Within three working days of discharge, the provider must communicate all relevant information to the GP, including any prescribing activity.

##### Children

On receipt of referral the provider must appropriately identify any children with bladder and bowel dysfunction who should firstly be assessed and treated by a health visitor or school nurse for Level 1 baseline and toilet skills assessments and care pathways (see Map of Medicine). This is subject to local variations. If a level 1 baseline and toilet skills assessments should have taken place outside of this service and has not the provider must provide assessment education to the child’s health visitor or school nurse.

For an example of a Paediatric Referral Form see here:



If the child has not responded to initial management and/or treatment at level 1 with the health visitor or school nurse and where further intervention is required, the patient should be referred into the paediatric bladder and bowel dysfunction service for specialist advice, assessment, treatment and review. The level 1 assessment and management plan should be included with the referral.

The service must operate within an integrated model, working in partnership with primary and secondary care and children’s service such as education.

Complex children would benefit from joint consultation which should be arranged with multidisciplinary input across secondary, tertiary, community care, where appropriate, this must be organised by the provider.

The service will improve the quality of life for children and young people aged 0 to 19 with bladder and bowel dysfunction.

An examples of a frequency and volume chart/ 3 day bladder diary and references for QoL tools can be seen here:



QoL tools for children: PinQ: a valid, reliable and reproducible quality-of-life measure in children with bladder dysfunction. Bower WF, Sit FK, Bluyssen N, Wong EM, Yeung CK. J Pediatr Urol. 2006 Jun;2(3):185-9 and Development of a validated quality of life tool specific to children with bladder dysfunction. Bower WF, Wong EM, Yeung CK. Neurourol Urodyn. 2006;25(3):221-7.

The provider must implement a community based nurse led model ensuring that the service:

* Offers health promotional advice in relation to bladder and bowel dysfunction.
* Offers clinical assessments that are evidence based and facilitate review as per care pathway.
* Provides a consultation service, offering clinical and product advice to patients, parents/guardians, relevant health care professionals, education services and others as appropriate to support the management of children with bladder and bowel dysfunction.
* Uses evidence based pathways of care, which are child/young person centred and family focused
* Provides Level 1 community based continence clinics for nocturnal enuresis and level 2 community based continence clinics that are accessible in all localities, with appropriately trained health care professionals (NICE Guidelines: Nocturnal Enuresis (bedwetting) in children (Published October 2010) and Constipation in Children (Published May 2010).

[www.nice.org.uk/nicemedia/live/13246/51367/51367.pdf](http://www.nice.org.uk/nicemedia/live/13246/51367/51367.pdf))

Initial Level 1 and 2 appointments will take approximately 1 hour and may include:

* Portable bladder scan
* Portable uroflometry as appropriate
* Health promotion and lifestyle advice, information leaflets, self care booklets
* Development of management and treatment plan, child/parent ownership
* Initiation of appropriate treatment
* Referral to other services as appropriate
* Prescription for containment products/medication
* Patients will be assessed and provided with mechanism (locally defined) for daily pads (disposable/reusable including washable containment products)
* Decision regarding follow up (subsequent 1/2 hour review(s))
* Communication to GP after first consultation within 3 working days
* Offers clinical assessment and review clinics in special schools and promotes continence through local and national guidelines.
* Works closely with adult services for the transfer of care for young people age 17 - 19 (where appropriate as some young people may require a longer transition)
* Is flexible and responsive, adapting to patient and carer needs and their requirements e.g. safeguarding children and young people issues, culture, language and disability.

The service must meet the key national requirements for NICE Clinical Guidelines. Nocturnal Enuresis (bedwetting) in children (Published October 2010) and Constipation in Children (Published May 2010).

[www.nice.org.uk/nicemedia/live/13246/51367/51367.pdf](http://www.nice.org.uk/nicemedia/live/13246/51367/51367.pdf)

The service must provide training (to support level 1 assessment at the point of referral), updates and education for primary care and others involved in the delivery of paediatric care for bladder and bowel dysfunction and support competency assessment. In particular training must be provided to health visitors and school nurses who are responsible for carrying out Level 1 assessments. This will ensure staff proficiency in the assessment and treatment of patients with bladder and bowel dysfunction. To include treatments for all idiopathic continence problems including nocturnal enuresis, constipation, delayed toilet training.

The provider must also ensure that training is provided to all agencies (both independent voluntary or statutory sector) that provide intimate personal care to a child or young person. Such persons/professionals and required competencies must be identified, recorded and reviewed at least annually. Training should be provided in the settings in which the child is cared for including nurseries, schools, leisure settings and others as appropriate.

**The service must:**

* Triage referrals on a daily basis and support only appropriate referrals for Level 2 assessments. Triage to be carried out by a specialist paediatric continence nurse(s).
* Following triage urgent referrals to be directly referred within 24 hours and GP informed within 3 working days
* Liaise with the referrer to discuss referrals as appropriate and if required
* Provide an appropriate assessment within 28 calendar days of receiving referral.
* Develop outcome based personalised care management plans as appropriate following assessment utilising the Map of Medicine pathways with parent/guardian

Please see examples of Map of Medicine pathways embedded here, local variation may apply.



Undertake periodic reviews to monitor the effectiveness of care management/treatment plans and to ensure adequate clinical improvement has been made.

Patient follow up, if required, (15-30mins on complexity) will be Map of Medicine pathway specific (max number of 6 visits) and will include:

* Bladder problems
* Day time wetting
* Nocturnal enuresis
* Delayed toilet training
* Bowel problems
* Idiopathic constipation/soiling
* Rectal irrigation
* Clean intermittent catheterisation

Provide telephone advice to patients, parents/guardians as required (Mon – Friday, 9am – 5pm excluding Bank Holidays)

Refer patients for onward referral to consultant paediatricians within secondary care as appropriate.

The service should hold joint clinics with consultant paediatricians or others as appropriate to facilitate multidisciplinary working and integration with those involved in the assessment and management of children and young people bladder and bowel dysfunction and particularly those with complex problems (and under 1 year) including dysfunctional voiding, neuropathic disorder.

Patients who Do Not Attend (DNA) on more than two occasions must be discharged from the service and their GP informed.

##### Response time and prioritisation

Following the initial assessment, management and referral to the paediatric bladder and bowel dysfunction service, the service must adhere to the response times set out below:

* Referrals to be triaged daily Monday to Friday by a paediatric continence nurse specialist(s) within 24 hours.
* Appointment for assessment to be scheduled within 28 calendar days from referral.
* Home visits to be offered on an individual clinical needs basis (see criteria)

Follow up to be determined on an individual basis and agreed with the patient and/or parent/guardian (max number of 6 visits within the patient pathway and determined by clinical need).

Follow ups may be via telephone

Clinical exception (more than 6 follow ups for children with long term conditions/congenital abnormalities) agreed with the referring GP and the provider.

Figure 2: Service Pathway

##### Generic adults and children

###### Prescribing

For those patients requiring medication, and/or products such as catheters, leg bags or other appliances via a specialist nurse or physiotherapist prescription, the provider must ensure that pathways are in place to ensure that prescriptions are coded to relevant individual GP practices linked to their overall prescribing budget. Repeat prescriptions will be organised through the GP practice. GPs would be required to review medication as per care pathway with shared care approach to medication thereafter between the provider and the GP in consultation with the patient. It is recommended that the provider uses the locally agreed prescribing formulary for continence care.

###### Containment products

In the UK, absorbent containment products are available free of charge on the NHS via GPs or local continence services.

For those requiring daily containment products (free on the NHS), patients will be identified at clinical assessment undertaken by the provider using a locally determined criteria where incontinence is deemed regular and daily, ranging from moderate to very severe. Patients who are deemed to have light (less than moderate) continence needs, following assessment will not be eligible as part of this service for daily pads. The provider must ensure patients will be referred to a home delivery company that meets NHS contract standards for continence products or equivalent. The provider must ensure that the home delivery company is declared as a subcontractor throughout the accreditation process. This will support the delivery of containment products direct to patient’s homes or patients may collect from a local pharmacy. Confidentiality to be maintained at all times.

The range available varies between healthcare providers, depending on local budgets, and patients may need to purchase containment products themselves - either because pad provision will depend on local arrangements or because they use more containment products that their provider feels they need, or because they prefer a particular brand that is not supplied free-of-charge.

Self-purchase is not difficult, as containment products are widely available from high street pharmacies, supermarkets and by mail order. It can prove expensive, however, as patients are unable to negotiate the bulk discounts available to healthcare providers. Regulators also need to formulate more equitable policies regarding VAT. Although individuals can purchase a certain number of incontinence products without paying VAT, and without filling in an exemption form, VAT has not actually been abolished on these containment products in the UK.

Although it is important to contain costs, it is also important to remember that cheaper containment products may have a lower performance. As a result, although unit costs are reduced, more containment products may be consumed, which can cost more overall.

The primary requirements for containment products which are free through the NHS are:

* Rapid absorption and retention of urine
* Isolation of wetness from the skin
* Reduction of odour
* Hygiene
* Comfort
* Simplicity
* Low noise factor in order to promote privacy and dignity

A typical person with incontinence requires absorbent containment products during the day and may require an additional, heavier-performing product at night. Therefore the provider must ensure that the patient as part of the treatment plan is aware that they will receive a minimum of 3 pads for daily continence, through the delivery service. It is the provider’s responsibility to ensure that the delivery company adheres to the requirements of this specification.

The number of daily containment products will be determined locally however for the purpose of this specification the minimum provided shall be three pads daily per individual. It is not possible to determine a maximum as this is a clinically determined decision. The provider must ensure that the clinical lead for the service acts as authoriser should four of more containment products be required. The decision re authorisation must be completed within 24 hours of the request for containment products.

Any patient who requires pads following a secondary care procedure e.g. laparoscopic radical prostatectomy will be referred to the provider and the provider must ensure pads are provided for 8 weeks post surgery with provider clinical review undertaken at 8 weeks to determine if further containment products are required.

For patients with palliative incontinent pad needs, automatic delivery to the home should be organised by the provider as part of the patient’s pathway of care. Prior to hospital discharge, patients must have undergone an assessment by a registered nurse who has completed an accredited module for urology and containment products organised.

For children, the provider must ensure access to enuresis alarms as required as part of a free loan system. Partnership working with occupational therapists is also required re assessment for potty chairs, seat reducers, and other items of assistive technology.

For patients with a learning disability, the provider should ensure partnerships with Community Adult Mental Health (CAMH) and adult services are established to support challenging behaviour around continence issues with a referral where appropriate.

#### Population covered

The service will be accessible for patients registered with a GP practice and will be delivered from centres as close to home as possible.

#### Any acceptance and exclusion criteria

##### Adults

The service will accept female/male referrals for patients with lower urinary tract symptoms and/or incontinence as per inclusion/exclusion criteria.

The service will adhere to the following exclusion criteria for females, unless local agreement is in place:

* Haematuria (frank, microscopic or Dipstick)
* Suspected gynaecological malignancy
* Palpable bladder
* Abdominal or pelvic mass
* Recurrent UTI – more than 4 in 12 months of unknown cause
* Neuropathic bladder (of unknown cause)
* Recent Gynae/urological surgery
* Suspected fistula
* Previous Pelvic irradiation
* Incontinence associated with pain

The service will adhere to the following exclusion criteria for males unless local agreement is in place:

* Men under 50 years particularly with irritative lower UTI symptoms who must be referred to secondary care
* Haematuria (frank microscopic or dipstick)
* Elevated age- adjusted PSA (prostate specific antigen)
* UTI/ Prostatitis
* Raised creatinine
* Palpable bladder or abdominal/pelvic mass
* Neuropathic bladder of unknown cause
* Previous urological surgery excluding circumcision and benign scrotal lumps
* Rapid onset of symptoms (less than 4 months)
* Digital Rectal Examination (DRE) suspicious of prostate malignancy

NB: Patients attending found to have a first degree relative who has had prostate cancer must be counselled appropriately regarding the advisability of reporting for annual PSA testing/ Digital Rectal Examination (DRE).

##### Other Exclusions

This would include pathway elements for non-complex continence care management undertaken by community nursing team or registered nurses within care homes who have attended a 2 day core continence training course to support basic assessment needs e.g. product fitting supported by standard operating procedures. This training must be facilitated by the service to ensure adherence to local procedures and pathways. If a nursing home referral is reviewed at triage and it is deemed appropriate and clinically indicated to be seen within the service it would be directed to either a level 1 or level 2 clinic appointment.

##### Bowel Exclusions

* Unexplained change in bowel habit
* Black tarry stool and not taking ferrous sulphate
* Palliative care patients
* Undiagnosed or unexplained bleeding from the rectum
* Signs of obstruction
* Stoma patients
* Rectal prolapse
* Third degree haemorrhoids

##### Children

###### Referral criteria & sources

If adequate clinical improvement has not been made following the initial assessment and management (level 1) of children and young people by health visitor or school nurse, patients should be referred to the paediatric bladder and bowel dysfunction service for specialist advice, assessment, treatment and review.

Children under 2 years with ano-rectal anomalies, neuropathic bladder and bowel etc. must firstly have been reviewed by a paediatrician if clinically indicated before entry to this service. Early referral is encouraged for children with potential for delayed toilet training, such as Downs, autistic spectrum disorders is encouraged to facilitate toilet skill programmes. Entry at this point may be subject to local agreement.

The paediatric bladder and bowel dysfunction service including transition service is available to children and young people from the age of 0 to 19 with bladder and bowel dysfunction, who are registered with a GP.

Young people will be assessed up to the age of 16 years; from there they will enter a transitional period to 19 years and then transfer to the adult service.

###### Referral route

There is an open referral system:

* Self-referral (parent/guardian, young adult).
* Referrals from primary care healthcare professionals (including GPs, health visitors, and school nurses).
* Secondary care referrals (i.e. consultant paediatricians).
* Others as appropriate.

#### Interdependencies with other services

Providers shall be required to link seamlessly with all specialist and primary care services. This includes the encouragement of timely referral, links with link nurses, allied health professionals and the independent sector.

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 3 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 incontinence. The Good Practice in Continence Services (Department of Health 2000)

<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005851> states that various 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 providers shall ensure that all performers of services to patients should be familiar with the wider healthcare community and be able to make referrals to other services, including specialist services, as and when required. Partners will include:

* Community Services
* Acute Trust
* Social services
* Patient Forums
* All GP Practices
* Health and Informatics Service

### Applicable Service Standards

#### Applicable National Standards

##### Provider essential

The provider will deliver services effectively to patients. The provider is required to meet, as a minimum, the following standards:

* 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

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 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 book an appointment for patient, by contacting them by telephone and choosing mutually convenient time within 28 calendar days.

Confirmation sent to patient. Should booking the appointment not be possible within the identified timescale, this should be reported to the referring GP with reason. Text reminders encouraged.

The provider must convey all/any suspicious findings by phone to the referring GP for urgent/immediate action

Review appointments must be arranged by the provider at mutually convenient time and place for patients. On discharge the provider must ensure that both patient and GP are aware that entry back into the service is patient/GP responsibility.

###### Telephone support/advice line support

Provider to meet all aspects of relevant NICE guidance as detailed in the evidence base.

Provider to meet Ionising Radiation (Medical Exposure) Regulations (IRMER) standards and must conform to all aspects of Imaging Services Accreditation Scheme (ISAS), Royal College of Radiologists Imaging Services Accreditation Scheme Standard: Statements, Rationales and Criteria. (Jan 2009).

<http://www.rcr.ac.uk/publications.aspx?PageID=310>

###### Provider to be CQC registered.

If non NHS provider, must hold information sharing agreement as per Caldicott principles, namely an information governance statement of compliance which has been assured by external assessors and is accessible to the public.



###### The service must:

* Provide fully skilled and trained, appropriately qualified personnel (see competency schedule in SECTION 1 APPENDIX 1), and provide a competency based training package to ensure staff have the required knowledge and skills to deliver safe and effective practice. For example specialist nurses, GPs with a special interest in the condition, ultrasonographers, and consultant urologists and physiotherapists and occupational therapists, provided that they have had appropriate training and demonstrate the required competencies.
* Physiotherapists must be registered with the Health Professional Council. Those working at level 2 should hold the postgraduate certificate (either physiotherapy in women’s health or Continence for Physiotherapists0 or equivalent. Level 1 physiotherapists must have completed postgraduate specialist training in the assessment and management of bladder and bowel dysfunction.
* For the children’s specialist nurses, staff must hold the following qualifications, Registered Sick Children’s Nurse (RSCN), health visitor or degree school nurses. Non medical prescribing qualifications are desirable.
* Ensure appropriate professional development/training is sourced and accessed by the paediatric continence nurses. This must include safeguarding children and vulnerable adults training and the triage of and management of referrals.
* Ensure staff are specialist, trained and experienced and can fully understand the implications/impact of incontinence on health and wellbeing. Patients feel that the sensitivity and nature of the condition requires an understanding and empathic approach promoting dignity and respect, with a focus on empowering and encouraging patients on all aspects of self care as part of a value base.
* The gold standard model would be the active involvement of secondary care specialists (nurses, physiotherapists, occupational therapists) delivering appropriate care within this community service with secondary care specialists (nurses, physiotherapists, occupational therapists, doctors) supporting in an advisory capacity, again where appropriate.
* Senior lead clinician with a managerial responsibility may be either be a nurse, physiotherapist or continence medical consultant with masters level and management qualification and 5 years experience.
* 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 monitoring storage and retrieval of prescription pads.
* 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, which must involve attendance at theatre and clinic sessions in secondary care, attendance at conference at least annually. 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
* Provide information and advice leaflets, DVD, visual tools, website for patients. Other formats, such as Braille, large print, audio cassette or CD, must be made available if the need has been identified. Facilitate a group approach and expert patient involvement where appropriate and support carers as required. Information should be age and language appropriate.
* Be responsive to people with learning disabilities, mental health problems and those from ethnic minority groups. The provider must ensure all staff undertake mental capacity training, equality and diversity training and conflict resolution training

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

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

The service must be provided in a geographically convenient, easily accessible location which:

* Complies with health and safety legislation;
* has disabled access;
* Has appropriate waiting and treatment areas;
* Is appropriately furnished and equipped with necessary equipment;
* Meets cleanliness and hygiene standards.
* Is easily accessible via public transport
* Has available parking for patients

The provider must raise awareness of the service amongst other health care professionals to minimise referral delays. Raising awareness should extend to public and potential service users to promote better understanding of the service (including self-referral options). This should extend to carers and their children and young people.

###### The provider must fulfil patient and public expectations of

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

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

* Management supervision;
* Clinical supervision;
* Safeguarding supervision (Safeguarding issues to be referred to named nurses within the Provider Services Safeguarding Team).

#### Applicable local standards

This is intended as a non-exhaustive list. Clause [16] takes precedence.

### Key Service Outcomes

* Satisfaction with the quality of the service
* Number of adults and children cured, treated or symptoms alleviated whilst within the service or post discharge
* Number of adults and children self-managing to agreed management plan at nine months
* Reduction in avoidable secondary care attendance, admission
* Reduction in UTIs
* Reduction in unnecessary treatment and inappropriate reliance on products for the containment of urinary/faecal incontinence.

### Location of Provider Premises

The Provider’s Premises are located at:

[Name and address of Provider’s Premises OR state “Not Applicable”]

### Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]

## ESSENTIAL SERVICES

[For local agreement]

For the purpose of this service specification it is essential that the provision of containment products is at all times maintained

The tariffs within this specification do not include the payment for containment products due to the uncertainty of activity levels. Containment products are free on the NHS to patients who meet the criteria.

Traditionally, the provider (where there is one) is given a budget (is/was from the PCT) based on the expected activity for that area to cover the pad costs. The provider generally negotiates the best cost possible with an external company to purchase pads and has them provided/delivered to right person right place etc. The provider will use locally agreed criteria to ensure the right people enter into this system and pads are provided free to them in order to meet the management plan goals.

For AQP the above is not sustainable therefore provision is to be agreed locally.

Therefore the number of daily containment products will be determined locally however for the purpose of this specification the minimum provided shall be three pads daily per individual. It is not possible to determine a maximum as this is a clinically determined decision. The clinical lead for the service or senior nurse must act as authoriser should four of more containment products be required. The decision re authorisation must be completed within 24 hours of the decision to give containment products

Until a long term solution is locally agreed an interim solution must be sought. A system of recharging is suggested. The process for this would be:

Provider assesses patient and determines need for containment products

Provider would arrange provision

Provider must collate containment products monthly with expenditure monitored to include an appropriate level of detail (reporting can be agreed locally)

This must be submitted to the commissioner and be subject to review

Once authorised the equivalent payment would be made to the provider

A quarterly audit must be carried out to ensure that the provider is compliant with the assessment criteria for containment products provision.

To support the identification of the average annual consumable budget per patient, the total consumable budget can be divided by the total number of patients with consumables. It should also be noted that VAT costs would need to be shown within this context.

The following are options for the long term solution:

* Use a methodology to predict activity (number of people) requiring
* pads and apportion the previous or new consumable budget to individual GP budgets within consortia. The provider assesses the patient against the criteria and contacts the external company who invoice the GP directly. This could also support enuresis alarms.
* Use a voucher scheme. The provider assesses the patient against the criteria, gives them a voucher for the product which can be exchanged say at Boots. The patient signs an agreement and must use the supply for 8 weeks. This gives patient choice as there is an opportunity to top up the voucher e.g. purchase a pull up instead of a pad. This is not without difficulty as to variability of pads etc. This could also support enuresis alarms.
* Use personal health budgets. Patient meets the qualification criteria and uses their direct payment to purchase pads/alarm. This gives patient choice and could also support enuresis alarms

### Personal Health budgets and AQP:

Personal health budgets are intended to give people more choice and control over the NHS funded services they receive. They are a way of commissioning services at the level of the individual. At the heart of a personal health budget is a care plan which sets out the individual’s health needs and includes outcomes, the amount of money in the budget and how this will be spent. This is developed in partnership with the person and is agreed by the NHS. The Budgets can be used for a range of services, including traditionally provided services, those included on local Any Qualified Provider lists or non-traditional services such as hydrotherapy, acupuncture or gym membership.

Personal health budgets are currently being piloted in the NHS in England. The pilots involve people with a range of long-term conditions such as COPD, stroke, diabetes and neurological conditions and mental health needs. People in receipt of NHS Continuing Healthcare (many of whom previously received personal budgets in social care) are a key group likely to benefit from personal health budgets. The pilot programme is due to end in October 2012 when the independent evaluation report will be published.

Although they are currently being piloted, there is a clear government commitment to roll out personal health budgets. This was set out most recently on 4 October when the secretary of State announced that subject to the evaluation, by April 2014 everyone in receipt of NHS Continuing Healthcare will have a right to ask for a personal health budget, including a direct payment. More information on personal health budgets can be found at: <http://www.personalhealthbudgets.dh.gov.uk>

### Prescribing

For the purposes of this specification consideration of prescribing of appliances and medication may include the use of a centralised prescribing model where services have their own PPD prescribing code. This would require local agreement.

## INDICATIVE ACTIVITY PLAN

A table which includes all tariffs and the predicted amount of activity for the service should be created locally and inserted here. Figures should demonstrate activity levels within each CCG in the area to be served by the service.

## ACTIVITY PLANNING ASSUMPTIONS

### **Commissioning Ambitions based on Activity Plan**

[State “Not Applicable” where appropriate OR where inserted, the Commissioning Ambitions must not conflict with information in Service Specifications. The standard template published alongside this contract is recommended]

### **Capacity Review**

[Where relevant to the Service, relevant parts of the Activity Plan and Capacity Review should be inserted here.]

Activity by the provider has exceeded the seasonally profiled activity plan for the preceding three-month period by more than 5%

## ACTIVITY MANAGEMENT PLAN

[Insert/append Activity Management Plan]

## NON-TARIFF AND VARIATIONS TO TARIFF PRICES

### **Non-Tariff Prices**

[For local agreement]

### **Variations to Tariff Prices**

[For local agreement]

## EXPECTED ANNUAL CONTRACT VALUES

A table which includes all tariffs and the predicted amount of activity and annual contract values for the service should be created locally and inserted here. Figures should demonstrate activity levels within each CCG in the area to be served by the service.

The AQP impact assessment shows that the overall cost of procuring services under AQP is lower than existing arrangements:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_128457>

## QUALITY

### **Part 1 - Quality Requirements**

Table 2: Quality Requirements

| Technical Guidance Reference | Quality Requirement | Threshold | Method of Measurement | Consequence of breach |
| --- | --- | --- | --- | --- |
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**Local Requirements to be locally determined with suggestions below:**

Table 3: Quality Performance Indicators

| Quality Performance Indicator | Indicator | Threshold | Method of measurement | Frequency of monitoring | Consequence of breach |
| --- | --- | --- | --- | --- | --- |
| Number of patients referred to the service and are triaged within 24 hours | Patient activity | 95% | Recorded triage activity | Monthly | National consequence – see clause 32 |
| Number of patients accepted to the service and seen initially within 28 calendar days | Patient activity | 95% | Base line symptom profile and quality of life questionnaire | Monthly | National consequence – see clause 32 |
| Number of patients at triage given level 1  and level 2 appointments | Audit to evaluate the clinical reason for the decision to proceed to a level 2 appointment | 100% of level 2 appointments | Audit to evaluate | Twice yearly | National consequence – see clause 32 |
| Clinical audit using NICE Quality Standards / Essence of Care Benchmark or Essential Steps | Audit plan including audit tools in place for   * Level 1 * Level 2 * Children | One adult and one children audit completed | Audit report | Annually | National consequence – see clause 32 |
| Education and training delivered to HCPs across the health economy | Number of HCPs receiving continence awareness education that have improved their knowledge and application | 100% of educational contacts to be included within the audit | Audit to evaluate success of educational contacts | Annually | National consequence – see clause 32 |
| Service User/Carer Experience  Including Experience Improvement Plan | A client user survey is undertaken from service users to report into pathway experience. | 100% of patients must be offered  40% of questionnaire must be completed | Audit to evaluate | Report detailing experience with recommended improvement plan due month 5 and month 11. | National consequence – see clause 32 |
| Quality of Life and symptom profile questionnaire | Assessment Form/ Questionnaire distributed to   * 100% of patients at 6 months, * 100% of patients at 9 months | 40% of questionnaire must be returned | Audit to Evaluate | Annually | National consequence – see clause 32 |
| Infection control: The number of urinary catheters in situ for patients within the service | Audit to evaluate the number of  catheters in situ for under 29 days and over 28 days and those patients presenting with a UTI | 100% | Audit to evaluate | Quarterly | National consequence – see clause 32 |

### **Nationally Specified Events**

Table 4: Nationally Specified events

| Technical Guidance Reference | Nationally Specified Event | Threshold | Method of Measurement | Consequence per breach |
| --- | --- | --- | --- | --- |
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### **Never Events**

Table 5: National Definition (part of standard contract)

| Never Events | Threshold | Method of Measurement | Never Event Consequence (per occurrence) |
| --- | --- | --- | --- |
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## QUALITY INCENTIVE SCHEMES

### **Part 1 - Nationally Mandated Incentive Schemes**

[Currently there are no National mandated incentive schemes for continence services. Local ones will have to be determined by commissioners]

### **Commissioning for Quality and Innovation (CQUIN)**

**Table 1: CQUIN Scheme**

[The Parties are recommended to use the on-line standard template for CQUIN schemes 2011/12 available on the website of the NHS Institute for Innovation and Improvement (at

<http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html>) to facilitate the completion and recording of their CQUIN scheme.

Where the Parties use the on-line standard template, a copy of the completed scheme must still be printed and appended to this Schedule 18 Part 2 in place of the tables below.]

Quality Incentive Payments can be agreed to be paid monthly or by single annual payments.

**PLEASE DELETE AS APPROPRIATE** “The Parties agree that Quality Incentive Payments shall be paid monthly and therefore the provisions set out in paragraphs 5 to 13 below shall apply.” **OR “**The Parties agree that Quality Incentive Payments shall be paid annually and therefore the provisions set out in paragraphs 14 to 19 below shall apply.

Table 6: Summary of goals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Goal Number | Goal Name | Description of Goal | Goal weighting  (% of CQUIN scheme available) | Expected financial value of Goal (£) | Quality Domain (Safety, Effectiveness, Patient Experience or Innovation) |
| 1 | Patient Experience | Write and monitor a service improvement action plan developed as a result of patient engagement strategy | 50.00% |  | Patient Experience Innovation |
| 2 | Reduction in Did Not Attends (DNAs) | Reduce overall number of DNAs from baseline by 10% and by 4th quarter | 25.00% |  | Safety Effectiveness |
| etc | Completion of pathway | Increase in the proportion of patients both adults and children cured, treated or symptoms alleviated whilst within the service as demonstrated by repeat of symptom questionnaire at 6 and 9 months and on completion of pathway | 25.00% |  | Safety Effectiveness |
|  |  | **Totals:** | **100.00%** |  |  |

Table 7: Summary of indicators

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Goal Number | Indicator Number**[[3]](#footnote-4)** | Indicator Name | Indicator Weighting  (% of CQUIN scheme available) | Expected financial value of Indicator (£) |
| 1 | 1 | Patient Experience | 50.00% |  |
| 2 | 2 | Reduction in DNAs | 25.00% |  |
| 3 | 3 | Completion of Pathway | 25.00% |  |
| Etc |  |  |  |  |
|  |  | **Totals:** | **100.00%** |  |

Table 8: Detail of Indicator 1

|  |  |
| --- | --- |
| Indicator number | 1 |
| Indicator name | Patient Experience |
| Indicator weighting (% of CQUIN scheme available) | 50.00% |
| Description of indicator | Write and monitor a service improvement action plan developed as a result of patient engagement strategy |
| Numerator | N/A |
| Denominator | N/A |
| Rationale for inclusion | Ensure patient engagement is meaningful and results support change where appropriate |
| Data source | Provider to develop action plan based on its own patient engagement activities |
| Frequency of data collection | Twice yearly action plan submission to commissioners |
| Organisation responsible for data collection | Provider to submit action plan to commissioners |
| Frequency of reporting to commissioner | end of every quarter |
| Baseline period/date | N/A |
| Baseline value | N/A |
| Final indicator period/date (on which payment is based) | N/A |
| Final indicator value (payment threshold) | N/A |
| Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner) | Service provider must have developed an action plan in relation to patient engagement activities undertaken during each quarter of the contract. The provider must demonstrate the following:   * variety of means of patient engagement (eg surveys, focus group) * at least 3 proposed actions developed as a result of patient feedback.   These actions should be tangible changes that will improve the service for the benefit of service users. They should specify a person responsible for completing the action and a deadline. The provider must be able to demonstrate monitoring of the action plan on a quarterly basis, through a RAG rating system. This will be a cumulative action plan, which will be added to at the end of every quarter, based on that quarter's patient engagement activities. By the end of the contract year there must be a minimum of 12 different actions, and information regarding the progress against the 9 actions specified by the end of quarter 3. |
| Final indicator reporting date | End of final quarter |
| Are there rules for any agreed in-year milestones that result in payment? | No |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? | No |

Table 9: Detail of Indicator 2

|  |  |
| --- | --- |
| Indicator number | 2 |
| Indicator name | Reduction in DNAs |
| Indicator weighting (% of CQUIN scheme available) | 25.00% |
| Description of indicator | Reduction in number of appointments that are classed as DNA |
| Numerator | Number of appointments classed as DNA during the contract year |
| Denominator | Number of appointments booked during the contract year |
| Rationale for inclusion | Reduction in the number of DNAs will ensure better compliance with treatment and therefore contribute to improved symptoms/condition; it will also ensure more efficient use of resources. |
| Data source | Provider to monitor number of appointments classed as DNA |
| Frequency of data collection | This data should be collected during every clinical session |
| Organisation responsible for data collection | The provider |
| Frequency of reporting to commissioner | Quarterly |
| Baseline period/date | First contract quarter |
| Baseline value |  |
| Final indicator period/date (on which payment is based) | Last contract quarter |
| Final indicator value (payment threshold) |  |
| Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner) | No more than 10% of all appointments that were originally booked with a patient should be classed as DNA. DNA is defined as an appointment where the patient booked in for that appointment does not turn up, and there is no evidence of prior notification to their GP practice, to the practice hosting the clinical session, or to the provider. |
| Final indicator reporting date | End of last contract quarter |
| Are there rules for any agreed in-year milestones that result in payment? | No |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? | No |

Table 10: Detail of Indicator 3

|  |  |
| --- | --- |
| Indicator number | 3 |
| Indicator name | Completion of Pathway |
| Indicator weighting (% of CQUIN scheme available) | 25.00% |
| Description of indicator | Increase in the proportion of patients both adults and children cured, treated or symptoms alleviated whilst within the service as demonstrated by repeat of symptom questionnaire at 6 and 9 months and on completion of pathway |
| Numerator | Total number of patients returning questionnaire having completed pathway of care |
| Denominator | Total number of patients accepted into the service |
| Rationale for inclusion | The rates of treatment and alleviation of symptoms will increase, with patients self managing and gaining more benefit from the education and treatment received |
| Data source | Provider |
| Frequency of data collection | Monthly |
| Organisation responsible for data collection | Provider |
| Frequency of reporting to commissioner | Quarterly |
| Baseline period/date | First quarter |
| Baseline value | N / a |
| Final indicator period/date (on which payment is based) | Last quarter |
| Final indicator value (payment threshold) | 70% |
| Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner) | At least 70% of those patients accepted into the service should be classed as having completed a pathway originally recommended for them upon the acceptance of referral. This only applies to those patients whose pathway is expected to be completed prior to the end of the contrac t year. |
| Final indicator reporting date | End of last quarter |
| Are there rules for any agreed in-year milestones that result in payment? | No |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? | No |

Table 11: Milestones (only to be completed for indicators that contain in-year milestones)

|  |  |  |  |
| --- | --- | --- | --- |
| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  | Total: |  |

Table 12: Rules for partial achievement at final indicator period/date

(only complete if the indicator has rules for partial achievement at final indicator period/date)

|  |  |
| --- | --- |
| Final indicator value for the part achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|  |  |
|  |  |
|  |  |
|  |  |

1. Subject to paragraph 2, if the Provider satisfies a Quality Incentive Scheme Indicator set out in Schedule 18 Part 2 Table 1, a Quality Incentive Payment shall be payable by the Commissioners to the Provider in accordance with this Schedule 18 Part 2.
2. The Commissioners shall not be liable to make Quality Incentive Payments under this Schedule 18 Part 2 to the Provider in respect of any Contract Year which in aggregate exceed the applicable Actual Outturn Value percentage for the relevant Contract Year set out below:

Table 13: Outturn Value percentage for the relevant Contract Year

|  |  |
| --- | --- |
| Contract Year | Maximum aggregate Quality Incentive Payment |
| 1st Contract Year | [For national determination and local insertion] |
|  |  |
|  |  |

and for the avoidance of doubt this paragraph shall limit only those Quality Incentive Payments made under this Schedule 18 Part 2, and shall not limit any Quality Incentive Payments made under any Quality Incentive Scheme set out in Schedule 18 Part 1 or Schedule 18 Part 3.

1. The Provider shall in accordance with clause [33] of this Agreement submit to the Co-ordinating Commissioner a Service Quality Performance Report which shall include details of the Provider’s performance against and progress towards the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in the month to which the Service Quality Performance Report relates.
2. The provisions set out in paragraphs 5 to 13 below apply in respect of Quality Incentive Payments made by monthly instalments. The provisions set out in paragraphs 14 to 19 apply in respect of Quality Incentive Payments made by a single annual payment.

**Monthly Quality Incentive Payments**

1. Where the Co-ordinating Commissioner and the Provider have agreed that Quality Incentive Payments should be made on a monthly basis by any Commissioners, then in each month after the Service Commencement Date during the term of this Agreement each relevant Commissioner shall make the default Quality Incentive Payment set out below to the Provider:

Table 14: Quality Incentive Payment

|  |  |
| --- | --- |
| Commissioners | Monthly Quality Incentive Payment – 1st Contract Year |
| [insert name of each Commissioner making monthly CQUIN payments] |  |
|  |  |
|  |  |

and the Provider and the Co-ordinating Commissioner may from time to time, whether as a result of a review performed under paragraph 6 below or otherwise, agree to vary the default monthly Quality Incentive Payment for any Commissioner set out above.

1. The Co-ordinating Commissioner shall review the Quality Incentive Payments made by the Commissioners under paragraph 5 on the basis of the information submitted by the Provider under this Agreement on the Provider’s performance against the Quality Incentive Scheme Indicators. Such reviews shall be carried out as part of each Review under clause [8].
2. In performing the review under paragraph 6 the Co-ordinating Commissioner shall reconcile the Quality Incentive Payments made by the relevant Commissioners under paragraph 5 against the Quality Incentive Payments that those Commissioners are liable to pay under paragraph 1 on the basis of the Provider’s performance against the Quality Incentive Scheme Indicators, as evidenced by the information submitted by the Provider under this Agreement.
3. Following such reconciliation, where applicable, the Provider shall invoice the relevant Commissioners separately for any reconciliation Quality Incentive Payments.
4. Within [10] Operational Days of completion of the review under paragraph 6, the Co-ordinating Commissioner shall submit a Quality Incentive Payment reconciliation account to the Provider.
5. In each reconciliation account prepared under paragraph 9 the Co-ordinating Commissioner:
   1. shall identify the Quality Incentive Payments to which the Provider is entitled, on the basis of the Provider’s performance against the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in those months of the relevant Contract Year that have elapsed at the time of the review;
   2. shall ensure that the Quality Incentive Payments made to the Provider in respect of completed Contract Years comply with the requirements of paragraph 2;
   3. may correct the conclusions of any previous reconciliation account, whether relating to the Contract Year under review or to any previous Contract Year; and
   4. shall identify any reconciliation payments due from the Provider to any Commissioner, or from any Commissioner to the Provider.
6. Within [5] Operational Days of receipt of the Quality Incentive Payment reconciliation account from the Co-ordinating Commissioner, the Provider shall either agree, or, acting in good faith, contest such reconciliation account.
7. The Provider’s agreement of the Quality Incentive Payment reconciliation account (such agreement not to be unreasonably withheld) shall trigger a reconciliation payment by the relevant Commissioner(s) to the Provider, or by the Provider to the relevant Commissioner(s), as appropriate, and such payment shall be made within [10] Operational Days of the Provider’s agreement of the reconciliation account and the Provider’s invoice.
8. If the Provider, acting in good faith, contests the Co-ordinating Commissioner’s Quality Incentive Payment reconciliation account:
   1. the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting such account, and in particular identifying which elements are contested and which are not contested;
   2. any uncontested payment identified in the Quality Incentive Payment reconciliation account shall be paid in accordance with paragraph 12 by the Party from whom it is due; and
   3. if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 13.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 13 the relevant Party shall pay any amount agreed or determined to be payable.

**Single annual payment of Quality Incentive Payments**

1. Where the Provider and Co-ordinating Commissioner have agreed that one single Quality Incentive Payment should be made to the Provider by any Commissioner at the end of each Contract Year, then at the end of each Contract Year during the term of this Agreement each Commissioner set out in the table in this paragraph 14 shall, subject to the Provider’s performance against the Quality Incentive Scheme Indicators, make a single Quality Incentive Payment to the Provider in accordance with the procedure set out in paragraphs 15 to 19 below.

|  |
| --- |
| Commissioners making single annual Quality Incentive Payment at the end of the Contract Year |
| [insert name of any Commissioner making a single annual CQUIN payments]  [Insert amount of the single annual CQUIN payment for each relevant Commissioner] |
|  |
|  |

1. The Co-ordinating Commissioner shall, within [10] Operational Days of the end of the Contract Year to which the Quality Incentive Payments relate or its receipt of final information from the Provider on its performance against the Quality Incentive Scheme Indicators during that Contract Year (whichever is the later), submit to the Provider a statement of the Quality Incentive Payments to which the Provider is entitled on the basis of the Provider’s performance against the Quality Incentive Scheme Indicators during the relevant Contract Year, as evidenced by the information submitted by the Provider under this Agreement.
2. Within [5] Operational Days of receipt of the Quality Incentive Payment statement from the Co-ordinating Commissioner under paragraph 15, the Provider shall either agree, or, acting in good faith, contest such statement.
3. The Provider’s agreement of the Quality Incentive Payment statement (such agreement not to be unreasonably withheld) shall trigger a payment by the relevant Commissioner(s) to the Provider, and such payment shall be made within [10] Operational Days of the Provider’s agreement of the statement and the Provider’s invoice.
4. In the event that the Quality Incentive Payment under paragraph 17 is paid before the final reconciliation account for the relevant Contract Year is agreed under clause [7] (*Prices and Payment*) of this Agreement, then if the Actual Outturn Value for the relevant Contract Year is not the same as the expected Annual Contract Value against which the Quality Incentive Payment was calculated, the Co-ordinating Commissioner shall within [10] Operational Days of the agreement of the final reconciliation account under clause [7] send the Provider a reconciliation statement reconciling the Quality Incentive Payment against what it would have been had it been calculated against the Actual Outturn Value, and a reconciliation payment in accordance with that reconciliation statement shall be made by the relevant Commissioner to the Provider or by the Provider to the relevant Commissioner, as appropriate, within [10] Operational Days of the submission to the Provider of the reconciliation statement under this paragraph 18.
5. If the Provider, acting in good faith, contests the Co-ordinating Commissioner’s Quality Incentive Payment statement under paragraph 15 or reconciliation statement under paragraph 18:
   1. the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting the relevant statement, and in particular identifying which elements are contested and which are not contested;
   2. any uncontested payment identified in the relevant statement shall be paid in accordance with paragraph 17 by the relevant Commissioner or the Provider, as the case may be; and
   3. if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 19.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 19 the relevant Party shall pay any amount agreed or determined to be payable.

### **Locally Agreed Incentive Schemes**

[For local agreement]

## ELIMINATING MIXED SEX ACCOMMODATION PLAN

Not applicable

## SERVICE DEVELOPMENT AND IMPROVEMENT PLAN

Table 15: Suggestions for development and improvement plans

| Description of Scheme | Milestones | Timescales | Expected Benefit | Consequence of Achievement/ Breach |
| --- | --- | --- | --- | --- |
| Healthy Bowel Clinics | Q1.   * Consider contractual arrangements top slice of laxative budget. * Increased referral rates and increased number of clinics.   Q2.   * Patients with bowel dysfunction have choice of venue * Reduced need to refer to secondary care   Q3.   * Triage enables patients referred direct to secondary care if clinically identified * Partnership and collaboration with local acute hospital and colorectal surgeons | Within one year of contract to enable increased equitable provision for bowel dysfunction. | * Monitoring of budget for laxatives available with savings identified and agreed with GPs * Local clinics accessible for patients with bowel symptoms * Improved journey for patients with bowel dysfunction * Direct referral if CA suspected * Responsive access to containment products for faecal incontinence if clinically found * Quality of life improved for patients with bowel dysfunction following assessment and treatment | Subject to clause [32] (Contract Management) |
| Trial without catheter service | Q1.   * Offer choice to patient regarding where the procedure takes place * Consider exclusion criteria with urologists * Q2. * Consider contractual arrangements for urological supplies | Within one year of service provision  Protocols and guidelines developed  Collaboration and partnership with supplies and secondary care | * Patients can have procedure in local clinic or at home if housebound * Time of appointment can be mutually agreed * Potential savings made with urological supplies contractor * Patients will not be required to spend a day in local hospital or take up bed overnight * Review of catheter timely and removal possible therefore potentially reducing catheter associated infections and risk of ill health or mortality * Reduced number of catheters or time with indwelling appliance reduced making savings and quality of life improved with removal |  |
| Integration of Stoma Services into community | Yr1. Q1.   * Agreed protocols and guidelines from steering group members to include multi-disciplinary health care workers.   Yr1. Q2.   * Single point of access * Access to local clinics   Yr1. Q3.   * Telephone advisory line * Joint clinics with secondary care   Yr2. Q1.   * Multi-Disciplinary Team (MDT) meetings relating to stoma patients and palliative care * Monitoring of prescription * Items   Yr2. Q2.   * Contractual supplies in community of stoma appliances with potential savings and choice in relation to where service user accesses items   Yr2.Q3.   * IT Data base to capture and monitor service user information to increase productivity and offer value for money | This may commence at any time but may take up to 2 years for completion. | * Patients have increased continuity and seamless care relating to stomas from hospital to home. * Patients offered to choice of local clinic or home visit if more appropriate reduce need to attend secondary care * Triage can assist that the patient will see the most appropriate practitioner appointment mutually agreed with patient * Partnership working and collaboration increased with consultants in secondary care. * Increase the use of MDT meetings for palliative care patients. * Monitor patients and prescribing trends to monitor cost and clinical effectiveness * Improve communication for stoma patients with advisory line |  |
| Develop care pathways to implement procedures and treatment options for children with medical appliances closer to home |  |  |  |  |

## SERVICE USER, CARER AND STAFF SURVEYS

### **Service User, Carer and Staff Surveys**

| Experience ‘domain’ Ref | Method of data capture | Tools / Frequency / Sample size | Output |
| --- | --- | --- | --- |
| 1. Patient / Service user experience | Survey to incorporate a set of questions that help the service understand holistically users’ experiences | Questionnaire  Use of appropriate delivery channels, e.g.:   * Paper based (e.g. postcard) * Online (e.g. Surveymonkey) * Other electronic   Survey questions should map to each of the relevant domains of an established patient experience model / framework (e.g. Picker Institute –Patient Centred Care)  Sample size = minimum 50 per quarter completed surveys | Quarterly Reports showing key themes and insights, along with action planned remedial steps, interventions, and follow-up work (identified priority areas)  Findings triangulated with other sources of service user insight evidence |
| 1. Patient / Service user | Active promotion of ‘NHS Choices’ online comments service | Services to actively promote and encourage user feedback through ‘NHS Choices’ online channel:   * On-going promotion and collation of comments | Visibility of promotional literature within designated service areas / appointment letters / at point of discharge etc.  Quarterly Reports to highlight any online activity and indicate any planned remedial steps, interventions, and follow-up work (identified priority areas)  Findings triangulated with other sources of service user insight evidence  The ‘Right to reply’ function of the ‘NHS Choices’ comments service, to be actively used by the service to respond to user comments, where appropriate |
| 1. Patient / Service user / carer experience | To actively promote an appropriate local public feedback service (e.g. PALs / Complaints) | Ongoing | Visibility of promotional literature within designated service areas / appointment letters / at point of discharge etc. |
| 1. Public & Patient Involvement | Communication of outcomes of patient experience data to public / service users | Organisational publications  In-service communications etc. | Evidence of publications / communication channels used to feedback to public. |

## CLINICAL NETWORKS AND SCREENING PROGRAMMES

[For local agreement and not to conflict with any information in Service Specifications]

## REPORTING AND INFORMATION MANAGEMENT

All information gathered for the purposes of reporting is subject to the requirements set out in clause [27], (*Data Protection, Freedom of Information and Transparency*) and clause [56] (*Compliance with the Law*).

### **National Requirements Reported Centrally**

1. The Provider and Commissioner shall comply with the reporting requirements of SUS and UNIFY2. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs), where applicable to the service being provided.
2. The Provider shall ensure that each dataset that it provides under this Agreement contains the Organisation Data Service (ODS) code for the relevant Commissioner, and where the Commissioner to which a dataset relates is a Specialised Commissioning Group, or for the purposes of this Agreement hosts, represents or acts on behalf of a Specialised Commissioning Group, the Provider shall ensure that the dataset contains the ODS code for such Specialised Commissioning Group.
3. The Provider shall collect and report to the Commissioner on the patient-reported outcomes measures (PROMS) in accordance with applicable Guidance.
4. The Provider shall comply with the national reporting requirements in relation to Sleeping Accommodation Breaches as set out in the Professional Letter.

### **National Requirements Reported Locally**

The Provider shall provide reports (content, format, method and timeframe to be agreed locally) covering the following:

#### Service Quality Performance Report

##### Activity Report

1. Provider performance against the Baseline Quality Performance & Productivity Requirements
2. Provider performance against the Incentive Scheme
3. Complaints Monitoring Report
4. Equality Monitoring Report
5. Implementation of experience surveys
6. Sustainability Report (see the Department of Health’s Sustainability Strategy ‘Taking the Long Term View’)

This list is based on current national reporting requirements and is subject to change.

### **Local Requirements Reported Locally**

1. The data should be stored in a secure electronic form, ideally a relational database (e.g. Oracle, SQL Server) unless otherwise agreed with the Commissioner. User access controls should be implemented to ensure conformance with the governance requirements. Regular backups of the data should be taken.
2. The agreed dataset (see below) should be submitted by the last working day of each month (for the previous month) to the nominated Commissioner contact in electronic form (e.g. Microsoft Excel) via the agreed medium (usually e-mail). Encryption to AES256 level is required unless the data is transmitted between two NHS Mail accounts. Alternatively, a direct link to the Provider database may be established.
3. The submitted data should be accurate, complete and as up-to-date as practicable. Yearly (financial year) data should be provided on each occasion to ensure that retrospective additions and amendments are picked up.
4. Data should be provided to the lowest level of granularity. Aggregated data is not acceptable unless otherwise agreed with the Commissioner.
5. The data set below is based on the Community Information Data Set (CIDS) (<http://www.ic.nhs.uk/services/in-development/community-information-programme/community-information-data-set-cids/community-information-data-set-cids-implementation-resource-page>). Providers of Community Services should capture the information within this data set from April 2012 subject to having suitable systems in place.
6. Note that additional fields have been included where deemed appropriate for the service. References to corresponding CIDS data items are included. Primary keys are highlighted in yellow.
7. The structure is slightly simplified in that some data items may have more than one value per row, e.g. Diagnosis Code on the Referral table. Additional tables may be used in these instances.
8. The data set below is based on the Community Information Data Set (CIDS)
9. (<http://www.ic.nhs.uk/services/in-development/community-information-programme/community-information-data-set-cids/community-information-data-set-cids-implementation-resource-page>). Providers of Community Services should capture the information within this data set from April 2012 subject to having suitable systems in place.
10. Note that additional fields have been included where deemed appropriate for the service. References to corresponding CIDS data items are included. Primary keys are highlighted in yellow.

The structure is slightly simplified in that some data items may have more than one value per row, e.g. Diagnosis Code on the Referral table. Additional tables may be used in these instances.

Table 16: Person Table

| Column | Notes | CIDS Data Item |
| --- | --- | --- |
| NHS Number |  | Person. NHS Number |
| NHS Number Status Indicator |  | Person. NHS Number Status Indicator |
| Local Patient Identifier | Number used to uniquely identify patient with provider | Person. Local Patient Identifier |
| Org Code (Provider) | National organisation code for provider | Person. Organisation Code (Code of Provider) |
| Birth Date |  | Person. Person Birth Date |
| Death Date |  | Person. Person Death Date |
| Postcode of Usual Address |  | Person. Postcode of Usual Address |
| GMP Code (Patient Registration) |  | Person. General Medical Practice Code (Patient Registration) |
| Gender |  | Person.Person Gender Code Current |
| Ethnic Category |  | Person. Ethnic Category |
| Religion |  |  |
| Sexual Orientation |  |  |
| British Armed Forces Indicator |  |  |
| Disability Code | May be more than one | Person. Disability Code |

Table 17: Referral Table

| Column | Notes | CIDS Data Item |
| --- | --- | --- |
| Local Patient Identifier |  | Service Referral. Local Patient Identifier |
| Org Code (Provider) |  | Service Referral. Organisation Code (Code of Provider) |
| Service Request Identifier | Number used to uniquely identify referral | Service Referral. Service Request Identifier |
| Referral Request Received Date/Time |  | Service Referral. Referral Request Received Date / Service Referral. Referral Request Received Time |
| Adult or Paediatric Service | Will normally be clear from age of patient |  |
| Source of Referral | GP, primary care HCP, secondary care HCP, self-referral or other | Service Referral. Source of Referral for Community |
| Referring Organisation Code | Organisation code of organisation who referred patient (if applicable) | Service Referral. Referring Organisation Code |
| Referring Health Care Professional Staff Group | Staff group of health care professional who referred patient (if applicable) | Service Referral. Referring Care Professional Staff Group |
| Referring Health Care Professional | ID/name of health care professional who referred patient (if applicable) | Service Referral. Referring Care Professional Staff Group |
| Symptoms | From referral form - may be more than one |  |
| Diagnosis Codes | Formal diagnosis provided by referrer - may be more than one | Service Referral. Diagnosis At Referral (Community Care) |
| Procedure Codes | Procedure(s) which contributed to condition (e.g. laparoscopic radical prostatectomy) - may be more than one |  |
| Family History of Prostate Cancer (men) | Yes/No |  |
| Obstetric History (women) | From referral form |  |
| Received Treatment for Same Condition Before | Yes/No |  |
| Under Care of Urologist (adults) | Yes/No |  |
| Under Care of Paediatrician (children) | Yes/No |  |
| Clinical Findings | From referral form |  |
| Date Triage Offered | Date on which the patient was first offered a date for triage |  |
| Triage Date |  |  |
| Triage Decision | Level 1, level 2, level 3 (complex), refer elsewhere (e.g. to urologist, colorectal surgeon or consultant paediatrician) or decline |  |
| Triage Reason for Onward Referral / Declination |  |  |
| Date First Appointment Offered | Date on which the patient was first offered an appointment following triage |  |
| First Appointment Date |  |  |
| Continence Type | Urinary, faecal or both |  |
| Continence Prevalence | Daytime, night time or both |  |
| Continence Severity Assessment | Light, moderate or severe |  |
| Referral Closure (Discharge) Date |  | Service Referral. Referral Closure Date (Community Care) |
| Referral Closure (Discharge) Reason | Reason for discharge, e.g. treatment completed, referred to secondary care, referred to adult service | Service Referral. Referral Closure Reason (Community Care) |
| Patient Status at Discharge | e.g. Cured, improving, symptoms alleviated, stable, deteriorating |  |
| Date Details Passed to GP | After discharge |  |
| Referral Notes | Any additional notes for this referral |  |

Table 18: Care Contact Table

| Column | Notes | CIDS Data Item |
| --- | --- | --- |
| Local Patient Identifier |  | Care Contact Activities. Local Patient Identifier |
| Org Code (Provider) |  | Care Contact Activities. Organisation Code (Code of Provider) |
| Service Request Identifier |  | Care Contact Activities. Service Request Identifier |
| Contact Identifier | Number used to uniquely identify contact | Care Contact Activities. Community Care Contact Identifier |
| Contact Date/Time | Date/time of patient contact | Care Contact Activities. Care Contact Date / Care Contact Activities. Care Contact Time |
| Date Appointment Booked | If relevant |  |
| Contact Duration (mins) |  | Care Contact Activities. Clinical Contact Duration of Care Contact |
| Contact Type | Triage, assessment, follow-up, enquiry | Care Contact Activities. Care Contact Type (Community Care) |
| Contact Subject | Who contact was with - patient, parent/guardian or patient proxy | Care Contact Activities. Care Contact Subject |
| Consultation Medium | e.g. Face-to-face, telephone | Care Contact Activities. Consultation Medium Used |
| Location Type | e.g. Home, clinic (face-to-face only) | Care Contact Activities. Activity Location Type Code |
| Site Code (of Treatment) | If contact not in home setting | Care Contact Activities. Site Code (of Treatment) |
| Attended or Did Not Attend Code |  | Care Contact Activities. Attended or Did Not Attend Code |
| Health Care Professional Staff Group | Staff group of health care professional involved in contact - may be more than one | Care Contact Activities. Care Professional Staff Group (Community Care) |
| Health Care Professional | ID/name of health care professional involved in contact - may be more than one |  |
| Earliest Reasonable Offer Date | Required for measurement of RTT | Care Contact Activities. Earliest Reasonable Offer Date |
| Earliest Clinically Appropriate Date | Required for measurement of RTT | Care Contact Activities. Earliest Clinically Appropriate Date |
| Cancellation Date | Date contact cancelled by provider or patient | Care Contact Activities. Care Contact Cancellation Date |
| Cancellation Reason | Clinical or non-clinical | Care Contact Activities. Care Contact Cancellation Reason |
| Date Replacement Appointment Booked |  | Care Contact Activities. Replacement Appointment Booked Date (Community Care) |
| Replacement Appointment Date Offered |  | Care Contact Activities. Replacement Appointment Date Offered (Community Care) |
| Activity Type | e.g. test, scan, examination, lifestyle advice - may be more than one | Care Contact Activities. Community Care Activity Type Code |
| Activity Result | Results of tests, scans, examinations, etc - may be more than one |  |
| Contact Outcomes | Any outcomes/decisions/actions arising from the contact - may be more than one |  |
| Contact Notes | Any additional notes for this contact |  |

Table 19: Care Plan Table

|  |  |  |
| --- | --- | --- |
| Column | Notes | CIDS Data Item |
| Local Patient Identifier |  | Care Plan. Local Patient Identifier |
| Org Code (Provider) |  | Care Plan. Organisation Code (Code of Provider) |
| Service Request Identifier |  | Care Plan. Service Request Identifier |
| Care Plan Identifier | Number used to uniquely identify care plan | Care Plan. Care Plan Identifier |
| Care Plan Creation Date |  |  |
| Responsible Health Care Professional Staff Group | Staff group of health care professional with overall responsibility for care plan | Care Plan. Responsible Staff Group |
| Responsible Health Care Professional | ID/name of health care professional with overall responsibility for care plan |  |
| Care Plan Start Date |  | Care Plan. Care Plan Start Date |
| Recommended Number of Follow-Ups |  |  |
| Date Referring GP Contacted | Where more than 6 follow-ups required |  |
| Product | e.g. Catheter, pads - may be more than one product required |  |
| Voucher Value | If vouchers provided to purchase products |  |
| Voucher Frequency | Frequency of issue of vouchers |  |
| Daily Pads Required? | Y/N - daily pads are currently free on the NHS |  |
| Number of Daytime Pads Per Day |  |  |
| Number of Night time Pads Per Day |  |  |
| Date Products Requested |  |  |
| Date Products Authorised | Date on which product requirement was authorised by clinician |  |
| Authorised By | ID/name of clinician authorising product requirement |  |
| Last Daily Pads Assessment Date | Date patient last assessed for daily pads |  |
| Next Daily Pads Assessment Date | Date patient will be next assessed |  |
| Care Plan Review Date |  |  |
| Patient Status at Review | e.g. Cured, improving, stable, deteriorating |  |
| Care Plan Review Outcome | e.g. Continue with plan, make minor changes to existing plan (e.g. provision of additional products), replace with new plan |  |
| Care Plan End Date |  | Care Plan. Care Plan End Date |
| Care Plan End Reason | e.g. Cured, new care plan required |  |
| Care Plan Notes | Any additional notes relating to the care plan |  |

Table 20: GP/HCP Contact Table

|  |  |  |
| --- | --- | --- |
| Column | Notes | CIDS Data Item |
| Local Patient Identifier |  |  |
| Org Code (Provider) |  |  |
| Service Request Identifier |  |  |
| Contact Date/Time | Date/time of contact |  |
| Contact Recipient | Registered (G)P or (H)ealth care professional |  |
| Health Care Professional | ID/name of health care professional |  |
| Contact Details | e.g. Updated following contact with patient, sent copy of referral letter |  |

Table 21: Questionnaire Table

| Column | Notes | CIDS Data Item |
| --- | --- | --- |
| Local Patient Identifier |  | Care Plan. Local Patient Identifier |
| Org Code (Provider) |  | Care Plan. Organisation Code (Code of Provider) |
| Service Request Identifier |  | Care Plan. Service Request Identifier |
| Questionnaire Type | (S)ymptom profile or (Q)uality of life |  |
| Issue Date | Date questionnaire issued - may be completed on several occasions (eg. at triage, after 6 months or at discharge - whichever is sooner - then after a further 3 months) |  |
| Help Requested Date | Where patient requests help to complete questionnaire |  |
| Help Provided Date |  |  |
| Return Date | Date questionnaire returned |  |
| Questionnaire Responses | Responses to all questions |  |
| Score | Responses are converted to a score to allow improvement to be measured |  |

### **Data Quality Improvement Plan**

For agreement at a local level.

– Competency Schedule Example

|  |
| --- |
| **COMPETENCIES**  **For Community Bladder and Bowel Integrated Service**  **(UPDATE EVERY TWO YEARS)**  **Full Name Base Date of Assessment**  **Name of Assessor Base Date of Assessment** |

Title: Competency for Continence Nurses Within Community Bladder and Bowel Integrated Services.

**Name ……………………………………………… Date ……………………….. Base**

| Knowledge  The ability to: Provide Patient Centred Care | | Self Assessment | | Formal Assessment | |
| --- | --- | --- | --- | --- | --- |
| Score | Nurse’s Comments | Score | Assessor’s Comments |
|  | Describe strategies on how the patient can be empowered to become an expert on their condition. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss the importance of achieving concordance between the clinician and the patient. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss the involvement in influencing and developing their own care planning including agreeing patient centred outcomes. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Describe health promotion and Public Health strategies related to continence care. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Critically assess the quality of life indicators and explore patients’ perceptions. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Critically assess and discuss appropriate appliance options, gain acceptance and demonstrate correct use. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss with the patient correct ways to access, review and empower them to make decisions around self-care. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  |  | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |

Key for Self-Assessment 1 = No knowledge / novice 2 = some knowledge / experience 3 = competent 4 = proficient 5 = very experienced and able to teach others

Title: Competency for Continence Nurses Within Community Bladder and Bowel Integrated Services

**Name ……………………………………………… Date ……………………….. Base**

| Knowledge  The ability to: Critically Explore the effects of incontinence in terms of morbidity and co-morbidity | | Self Assessment | | Formal Assessment | |
| --- | --- | --- | --- | --- | --- |
| Score | Nurse’s Comments | Score | Assessor’s Comments |
|  | Evaluate and discuss conditions causing incontinence. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss conditions which can be caused by urinary problems or symptoms. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss the conditions which can be caused by bowel problems or symptoms. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Critically examine the link between conditions and physical, psychological and social well-being. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Evaluate and discuss medications and their side effects which may influence continence in older people and those with disabilities. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss the importance of transition from Children’s Service to Adults for those with complex needs. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss and evaluate continence care for end of life. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |

Key for Self-Assessment 1 = No knowledge / novice 2 = some knowledge / experience 3 = competent 4 = proficient 5 = very experienced and able to teach others

Title: Competency for Continence Nurses Within Community Bladder and Bowel Integrated Services

**Name ……………………………………………… Date ……………………….. Base**

| Skill  The ability to: Demonstrate skills in assessing an individual with bladder or bowel dysfunction | | Self Assessment | | Formal Assessment | |
| --- | --- | --- | --- | --- | --- |
| Score | Nurse’s Comments | Score | Assessor’s Comments |
|  | Discuss the importance of a holistic assessment using local documentation and reflect on tools used. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss the differential interpretations of urinalysis and discuss the rationale for MSU or CSU. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss medications which may indicate referral or amendment and review. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Complete local pathway devised from clinical findings. Document action, reflect and evaluate tool effectiveness. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Critically discuss the relationship between diet and fluid intake and continence problems. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Reflect on the importance of patient involvement in care, carers. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Complete documentation appropriately and adequately. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Discuss the relationship between bladder residual volumes and impact on future care. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Demonstrate the ability to triage effectively and refer to secondary care when clinically indicated. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |

Key for Self-Assessment 1 = No knowledge / novice 2 = some knowledge / experience 3 = competent 4 = proficient 5 = very experienced and able to teach others

Title: Competency for Continence Nurses Within Community Bladder and Bowel Integrated Services

**Name ……………………………………………… Date ……………………….. Base**

| Skill  The ability to: Demonstrate a critical understanding on the management and treatment of an individual with continence problems. | | Self Assessment | | Formal Assessment | |
| --- | --- | --- | --- | --- | --- |
| Score | Nurse’s Comments | Score | Assessor’s Comments |
|  | Critically examine internal and external factors which will impact on incontinence | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Evaluate and discuss conservative bladder and bowel management and treatment. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Examine the rationale behind prompt voiding and individualised toileting. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Examine and discuss medications which might benefit symptoms when to use and side effects. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Prescribe medication within personal formulary and evaluate effectiveness. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Prescribe or recommend appliances for management of incontinence including catheters or sheaths and discuss physco socio economic impact of using such appliances. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  |  | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |

Key for Self-Assessment 1 = No knowledge / novice 2 = some knowledge / experience 3 = competent 4 = proficient 5 = very experienced and able to teach others

Title: Competency for Continence Nurses Within Community Bladder and Bowel Integrated Services

**Name ……………………………………………… Date ……………………….. Base**

| Knowledge  The ability to: Demonstrate clinical skills in relation to continence care following theoretical study | | Self Assessment | | Formal Assessment | |
| --- | --- | --- | --- | --- | --- |
| Score | Nurse’s Comments | Score | Assessor’s Comments |
|  | Perform bladder scan following local policy and record and document findings. Explain clinical findings and discuss when to refer on. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Perform catheterisation – indwelling, urethral, supra pubic, intermittent following local policy and procedures. Discuss the risks, benefits and legal implications. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Perform vaginal examination following local policies and procedures. Discuss rationale and legal implications. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Perform rectal examination following local policies and procedures. Discuss rationale and implications and when indicated refer on. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Perform vaginal assessment for prolapse following local policies and procedures. Discuss rationale and when clinically indicated refer on. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Perform rectal assessment for prostate following local policies and procedures. Discuss rationale and legal implications and when to refer on to secondary care. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Peform Uroflowmetry following local policies and procedures. Explain findings and discuss decontamination issues. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Perform tibial percutaneous neuro stimulation (PTNS) as per local policies and procedures. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |

Key for Self-Assessment 1 = No knowledge / novice 2 = some knowledge / experience 3 = competent 4 = proficient 5 = very experienced and able to teach others

Title: Competency for Continence Nurses Within Community Bladder and Bowel Integrated Services

**Name ……………………………………………… Date ……………………….. Base**

| Knowledge  The ability to: Demonstrate clinical skills in relation to continence care | | Self Assessment | | Formal Assessment | |
| --- | --- | --- | --- | --- | --- |
| Score | Nurse’s Comments | Score | Assessor’s Comments |
|  | Perform Peristeen rectal irrigation following local policies and procedures. Explain risks and benefits and legal implications relating to procedures. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Abdominal palpation following local policies and procedures. Discuss rationale and when to refer on. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Visual spinal examination following local policies and procedures. Discuss rationale and when to refer on. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Toilet skills assessment tool following local protocol rationale and discuss risks and benefits in delaying toileting. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Complete Barthel index tool following protocol and rationale. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  | Anal observation for children. Discuss rationale and when to refer on. | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
|  |  | 1 |  | 1 |  |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |

Key for Self-Assessment 1 = No knowledge / novice 2 = some knowledge / experience 3 = competent 4 = proficient 5 = very experienced and able to teach others

# 

1. Currency and Payment

Section 2 INDEX

[S2.1 Currency Statement 98](#_Toc317074686)

[S2.2 Pricing Methodology is as follows: 99](#_Toc317074687)

**Section 2 – Currency and Payment**

The currencies are defined as follows:

Tariffs are based on the provision of a level 1 or level 2 service pathway as specified and are reflective of the complexity / resources required for the presenting problem

The pathway price (at either level 1 or 2) will be based on an “average” combination of a first face to face (“new”) consultation and a series of follow up contacts (there is no exact number specified as this will be down to individual patients requirements but for the majority of clients it is anticipated that the maximum number of these would be up to 5 contacts (face to face) and that the average would be somewhat lower than that). Pathway prices include indirect and overhead costs to include the elements of triage and those self-referrers requiring support to complete initial documentation.

Follow up contacts made on a “non face-to-face” basis is covered via a separate tariff enabling the ongoing support, education and administration of the bladder and bowel dysfunction service.

Patients will be discharged following completion of the pathway, however if a patient is deemed to be an exception to the “average” pathway and requires significant or prolonged follow up, the provider should approach the commissioners to discuss an appropriate basis for re-imbursement.

Within the pathway development and in line with the current direction of travel an element of the pathway has been dedicated to the delivery of an outcome based specification, with providers completing a repeat of the baseline symptom profile and quality of life questionnaires at 6 and 9 months. The delivery of this outcome measure will accrue the additional incentive to the pathway tariff (percentage currently based on CQUIN payment which in 2011/12 attracts 1.5%) to help incentivise the delivery of improved outcome for the patient. This element/payment may be agreed locally and flexed appropriately to incentivise performance appropriately

* 1. Currency Statement

To provide a continence service to adults and children which includes analysis of the referral form (plus help to complete form for those self-referring), an initial assessment (to include all the attributes specified), up to six follow up appointments at either level 1 or 2, and patient experience/outcome questionnaire (as stipulated in the logic model).

The design of the currencies and tariff for this service is based on the following assumptions, adhering to the Department of Health’s guidance regarding high level principles for pricing of “any qualified provider” tariffs.

* That under the “Any Qualified Provider” model, the commissioner will pay any potential providers the same rate for a service delivered to achieve a specified outcome (as defined within the service specification)
* The suggested currency is based on the provision of a tiered service (levels one and two as per specification) for adult continence services and for paediatric continence a separate “face to face” and “non-face to face” tariff (as tiered approach is not as viable for paediatric services)
* As per the pricing guidelines an element of the pricing structure can be linked to the achievement of clinical outcomes where both feasible and appropriate (as defined within the service specification). This has been set at a provisional level of 1.5% of tariff as a direction of travel but can be subject to local aspirations and support for this suggested methodology.
* As per the guidance, suggested tariff prices are based on local prices and includes market forces factor and will need to be adjusted based on the location of where the service is delivered and what the nearest NHS Trust receives.
* An additional CQUIN payment will be applicable to AQP values (in line with standard acute contract) currently set at 1.5% of contract expenditure.
  1. Pricing Methodology is as follows:
* The suggested currency and tariff is based on the local Wirral model (as provided by Wirral Community NHS Trust) and the baseline of cost for delivering the service has been reconciled in line with the reference costs submission. (There will obviously be variation of service provision and expenditure nationally as to be expected and further benchmarking will take place with other AQP pilot sites to assess impact)
* The commissioner has worked with the local provider to determine the cost base of the existing service (baseline expenditure has been split between clinical staffing, containment products, appliances, indirect costs and overheads) to determine the appropriate split with which to base prices for the adult and paediatric services.
* The pricing structure excludes the containment products / products associated with the continence service (these are treated as a non-face to face contact within reference costs definition guidance) and these will need to addressed separately as referenced in Part 2 – Essential Services
* Activity information collated monthly for performance monitoring purposes and for annual returns such as reference costs have been used as the basis for the denominator for the creation of the proposed tariff.
* There has been no adjustment within the activity for adult face to face contacts with regards to case mix and follow up ratios and is assumed that that “average” overall mix of activity (both initial / subsequent attendances and levels one & two) will be reflective of other services. Any time limits applied to pathways should be determined by local agreement.
* Although local provision is considered to be relatively efficient, an adjustment has been made (circa 1.9%) to bring the local price down to the national average as per reference costs publication for the 2010-11 financial year (reference cost section - Community Nursing / Specialist Nursing) to reflect requirement for efficiency savings
* Suggested currencies and tariffs based on local provision (adjusted to national average).
  + 1. Adult Pathway

Pathway approach based on the (Wirral) average numbers of initial and subsequent attendances between service and patient, one payment made at the following rates for each pathway. (This again assumes that the overall activity is in line with average casemix within Wirral and should allow for a number of variations of initial / subsequent attendances and that overall number of follow up appointment is in line with service specification)

Level One - £82.19

Level Two - £129.42

Average (based on L1/2 casemix = £101.21)

* + 1. Adult Pathway (Outcome based)

As per above, reflecting pathway price approach but with % retained until achievement of outcome based measure as per specification

Level One - £80.95 (Additional £1.23 for achievement of outcome measures)

Level Two - £127.49 (Additional £1.94 for achievement of outcome measures)

* + 1. Adult Non-Face to Face Contact

Non-Face to Face Contact £17.07 (Based on local service, Telephone Manned 9am-5pm Monday - Friday).C

* + 1. Paediatric Face to Face Contact

£103.40

* + 1. Paediatric Face to Face Contact (Outcome based)

£101.80 (Additional £1.60 for achievement of outcome measures)

* + 1. Paediatric Non Face to Face Contact

£31.53

# 

1. Information Requirements for Patients

Section 3 INDEX

[S3.1 Background 103](#_Toc317074688)

[S3.2 Findings 103](#_Toc317074689)

[S3.3 Recommendations 103](#_Toc317074690)

**Section 3 – Information Requirement for Patients**

Guidance to the NHS on what specific information patients need to make an informed choice of qualified provider in the area of Continence.

* 1. Background
* NHS Wirral on behalf of the NHS Cheshire, Warrington and Wirral Cluster carried out patient and public engagement throughout the cluster to establish what specific information patients need to make an informed choice of qualified provider in the area of Continence.
* The engagement process was spilt into two parts. One part was in the form of focus groups run by the local engagement team and clinical specialist with current users of the service in Western Cheshire and in the Wirral. The second part was carried out by an external company commissioned to carry out engagement with users, potential users, carers and patient representatives across the cluster.
* 34 people in total attended the locally run focus groups and 355 people participated in the consultation lead by the external company.
* The findings of each part were collated into two reports. These can be found in the appendix.
* Engagement was also carried out nationally through the National Network of Parent Carer Forums
  1. Findings
* It has been identified from the engagement with a wide variety of patients, carers and patient representatives 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.
  1. Recommendations

Therefore the AQP- Continence project team recommend the following:

* + 1. Generic Service information

Information about the continence service should include:

* Information about continence, what it is, prevalence rates, types of treatment available etc (this will help to reduce the anxiety and embarrassment felt by patients needing to access the continence service).
* Information on expected outcomes noting that even if the patient cannot be ’cured’ , quality of life can be improved.
  + 1. Provider specific information

Choices in provision of care to include:

* Location of service
* opening hours
* Waiting times to access service and the time between each stage of the pathway.
* appointment process
* availability of male and female nurses
  + 1. Additional information shown to be important:
* Information on range of products and suppliers
* Quality assurance and standards 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 continence services.
* Provision of additional support mechanisms available (e.g. patient and carer support groups, expert patients etc.)
* Availability of additional integrated care services
  + 1. Accessibility

Information should be kept simple, presented clearly, and be easily accessed and understood by younger and adult service users.

Providers should communicate information about their services through a range of communication channels:

* Face to face via the GP or other Health Care Professional
* Via written communication in the form of leaflet or posters
* Via electronic communication such as websites and text messaging

Interviewees reported a preference for receiving information to help them choose a continence service provider through discussion with their GP (61%, n196) followed by a nurse (46%, n146) and via a leaflet (46%, n146). The ‘NHS choices’ website was the next most favoured method (40%, n128) followed by a pharmacist (25%, n78), by e-mail (22%, n70) and word of mouth (17%, n53), with posters (14%, n46), other websites (12%, n39) and text messaging (5%, n16) being the least popular methods.

1. Acknowledgements

**Annex 1: Acknowledgments**

|  |  |
| --- | --- |
| **Project Team** | |
| Cathy Gritzner | AQP Implementation Pack Lead |
| Geraldine Murphy-Walkden | Programme Lead |
| Sheena Hennell | Project Manager |
| Helen Jones | Project Officer |
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| Debra Ollerhead | Specialist Lead |
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| Richard Disley Jones | Information Lead |
| Anna Roberts | Contracts Lead |
| Helen Dingle | Prescribing Lead |
| Dr Scott Gaule | PPE Lead |
| Dawn Holt | PPE Lead |
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| Mark Doyle | Consultant Uro-Gynaecologist, Wirral University Teaching Hospital NHS Foundation Trust |
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| Kenny Henderson | Advanced urology nurse practitioner. Wirral University Teaching Hospital NHS Foundation Trust |
| Norma Howgate | Patient representative |
| Jane Scoble | Advanced urology nurse practitioner, Wirral University Teaching Hospital NHS Foundation Trust |
| Paul Kutarski | Consultant Urologist, Wirral University Teaching Hospital NHS Foundation Trust |
| Peter Todd | Paediatric Consultant, Wirral University Teaching Hospital NHS Foundation Trust |
| **Reference Group Members -** | **National** |
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| Department of Health |  |
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| Teresa Cook | Women's Health Physiotherapist/Lecturer, Bradford University |
| Sharon Eustice | Nurse Consultant for Continence, Peninsula Community Health, Cornwall |
| Sue Foxley, | Consultant Nurse - Continence Care kings College Hospital NHS FT |
| Anna Gill | Co- Chair National Network of Patient Carer Forum |
| Dr Danielle Harari | Senior Lecturer (Hon), Kings College London |
| Diane Jenkins | Joint Commissioning Manager, NHS Western Cheshire |
| Yvonne Lochhead | Associate Director for Governance and Patient Safety, Central and East Cheshire PCT |
| Dr Anne Maloney | Consultant in Geriatric Medicine, Halton General Hospital, Warrington |
| Joanne Mangnall | Clinical Nurse Specialist , NHS Rotherham |
| Lindsey McDonough | Continence advisor, NHS Western Cheshire |
| Sue Nowak | Team Leader, Expanding the Scope, PbR Development, DH |
| Professor David Oliver | National Clinical Director for Older Peoples Services |
| June Rogers | Team Director Promocon |
| Julie Vickerman | Clinical specialist Occupational therapist / Team Leader, Continence service, Chorley |
| Amanda Wells | Consultant Nurse/Head of Dept, Bladder,Bowel and Pelvic Floor Care Services, Northern Devon Healthcare NHS Trust |
| Annette Woodward | Advanced Practitioner Physiotherapist Continence management, Heart of England NHS Foundation Trust |
| Debra Yarde | Senior specialist Nurse, Bladder & Bowel Care Service. Devon |

1. Considerations

**Annex 2: Considerations (to be completed)**

**Please note Annex 2 is being updated - the following link will take you to the latest version of this document.**

<http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/Annex2.aspx>

1. Public Sector Equality Duty

**Annex 3: Public Sector Equality Duty**

The Equality Act 2010 replaces the previous anti-discrimination laws with a single Act making it easier for people to understand. It also strengthens the law in important ways, to help tackle discrimination and inequality. The Public Sector Equality Duty, which came into effect on 5 April 2011, sets out the responsibilities a public authority must undertake in order to ensure an environment that fosters good relations between persons of differing protected characteristics. Protected characteristics under the Equalities Act 2010 are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Duty has three aims. it requires public bodies to have due regard to the need to:

* eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
* advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
* foster good relations between people who share a protected characteristic and people who do not share it.

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. For more information please visit the Department of Health website and search for 'Equality and Diversity'.

1. Glossary

**Annex 4 – Glossary**

|  |  |
| --- | --- |
| **Any Qualified Provider** | Means that when patients are referred (usually by their GP) for a particular service, they should be able to choose from a list of *qualified* providers who meet NHS service quality requirements, prices and normal contractual obligations[[4]](#footnote-5). |
| **Audit** | Clinical audit is a process that has been defined as "a [quality improvement](http://en.wikipedia.org/wiki/Continuous_improvement) process that seeks to improve patient care and outcomes through systematic review of care against explicit [criteria](http://en.wikipedia.org/wiki/Criteria) and the implementation of change".  The key component of clinical audit is that performance is reviewed (or [audited](http://en.wikipedia.org/wiki/Audit)) to ensure that what should be done is being done, and if not it provides a [framework](http://en.wikipedia.org/wiki/Conceptual_framework) to enable improvements to be made. |
| **Caldicott Guardian** | A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing[[5]](#footnote-6). |
| **Care Pathway** | Means an evidence based plan of goals and key elements of care for a service user that facilitates the communication, coordination of roles and sequencing of the activities across their components of care. The aim of which is to enhance the quality of care by improving service user outcomes, promoting service user safety, increasing service user satisfaction and optimising the use of resources. |
| **Care Quality Commission** | Means the Care Quality Commission established under the 2008 Act ([CQC Website](http://www.cqc.org.uk)) |
| **Choose and Book** | Means the national electronic booking service that gives patients a choice of place, date and time for first hospital or clinical appointments. |
| **Commissioner** | Commissioners have a responsibility to purchase a range of healthcare and/or social care services from Providers to meet the needs of the populations for which they are responsible. These are subject to formal agreements and relate to a specified range of services. |
| **Community Based** | Services provided from a community setting (as supposed to a secondary care or primary care setting). |
| **CQUIN** | Commissioning for Quality & Innovation. A mechanism for incentivising quality improvement within NHS contracts.[[6]](#footnote-7) |
| **CRB** | Criminal Records Bureau |
| **Currency** | Means the unit for which payment is made and can take a variety of forms including episodic, block and package of care. The NHS costing manual sets out the principles for arriving at a total cost for each currency |
| **DDA** | Disability Discrimination Act |
| **Did Not Attend** | Means where the appointment did not take place where the patient failed to attend. |
| **Direct Access** | Referral straight from GP to the service without the need for secondary care triage (e.g. ENT). |
| **Discharge Summary** | Means a document issued to the service user by the lead Healthcare Professional or Care Professional of the service responsible for the service user’s care or treatment for the service user to use in the event of any query or concern immediately following discharge, containing information about the service user’s treatment, including without limitation:   * The dates of the service user’s referral or assessment; * The dates of the service user’s discharge; * Details of any care plan or treatment delivered; * Name of the service user’s responsible lead healthcare professional or care professional at the time of the service user’s discharge; * Any relevant or necessary information or instructions; * Contact details for the provider; * Any immediate post-discharge requirement for the GP or Referrer or other healthcare provider; * Any planned follow-up arrangements; and * The name and the position of the person to whom questions about the contents of the discharge letter are to be addressed; and complete and accurate contact details (including telephone number) for that person. |
| **HPC** | Health Professionals Council ([HPC Website](http://www.hpc-uk.org/)) |
| **IM&T** | Information Management and Technology |
| **In-scope, Out of scope** | In scope refers to the services that are to be commissioned as part of this service, and as defined within the service specification. If anything is considered out of scope, it will need to be commissioned separately. |
| **Interface Service** | Any service (excluding Consultant Led Services) that incorporates any intermediate levels of triage, assessment and treatment between traditional Primary Care and Secondary Care. Interface Services include assessment services and referral management centres. It does not include:   * Arrangements established to deliver primary, community or Direct Access Services, outside of their traditional setting * Non-Consultant Led Services for mental health run by Mental Health Trusts * Referrals to Practitioners with Specialist Interests for triage, assessment and possible treatment, except where they are working as part of a wider Interface Service arrangement.   Referral To Treatment (RTT) Periods to Interface Services are included in the 18 weeks targets. These are no longer central NHS targets, but are part of local contracting targets[[7]](#footnote-8). |
| **LA** | Local Anaesthesia |
| **Local Authority** | Means a county council in England, a district council in England or a London Borough Council. |
| **Monitor** | Means the public office established under the Health and Social Care (Community Health and Standards) Act 2003 with responsibility for authorising NHS Foundation Trusts and accountable to Parliament, and continuing under section 31 of the 2006 Act and any successor body or bodies from time to time, as appropriate.([Monitor Website](http://www.monitor-nhsft.gov.uk)) |
| **NHS** | Means the National Health Service in England. |
| **NHS Branding Guidelines** | Refers to the [‘Code of Practice for the Promotion of NHS Funded Services.’](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083556) |
| **NHS Constitution** | Means the constitution for the NHS in England set out in Law and/or Guidance from time to time which establishes the principles and values of the NHS in England and sets out the rights, pledges and responsibilities for patients and public and staff. [NHS Constitution](http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx) |
| **NHS Foundation Trust** | Means an NHS Foundation Trust as defined in Section 30 of the 2006 Act. |
| **NHS Trust** | Means a body established under the Section 25 of the 2006 Act. |
| **National Institute for Health and Clinical Excellence or ‘NICE’** | Means the special health authority responsible for providing national guidance on the promotion of good health and the prevention of ill health (or any successor body). ([Nice Website](http://www.nice.org.uk/)) |
| **National Standards** | Means those standards applicable to the provider under the Law and/or Guidance as amended from time to time. |
| **National Tariff** | Means the list of prices published from time to time by the Department of Health and applied in line with the Department of Health guidance relating to National Tariff construction and coding, charging and recording methodologies. |
| **Package of Care** | Means any assessment, treatment, nutrition, support, accommodation or other elements of care to be provided under the service and relating to a referral or an emergency presentation. |
| **Patient Booking** | Means the procedures for patient booking set out in Module E of the contract. |
| **Patient Choice** | Means the commitment to free choice in elective care, which requires that all patients who require a referral for elective care from their GP or primary care professional for a first appointment shall be able:   * To choose to be treated by any provider that meets relevant eligibility criteria and registered as a Qualified Provider. * To choose the time and date for their booked appointment, at the time they are referred. |
| **Patient Management Plan** | Means a plan to deliver services that are appropriate to the needs of the service user and that pays proper attention to the service user’s culture, ethnicity, gender, age andsexuality and takes account of the needs of any children and carers**.** |
| **Price/Tariff** | Price/tariff = Set price for a given currency unit. Has the meaning given to it in Clause 7.2 of the Contract Terms and Conditions. |
| **Provider** | Providers supply services to the Commissioners to meet the specification and against the terms of an agreement. |
| **Principles and Rules of Cooperation and Competition** | Means [the rules of procedure](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221) published from time to time by the Department of Health, relating to the commissioning and provision of NHS services, to support cooperation and competition in the interests of patients and taxpayers in relation to:   * Commissioning and procurement. * Cooperation and collusion. * Conduct of individual organisations. * Mergers and vertical integration. |
| **Qualification Process** | Means the process of registering providers to be eligible to deliver services to ensure that all providers offer safe, good quality care, taking account of the relevant professional standards in clinical services areas. The governing principles of qualification[[8]](#footnote-9) is that a provider should be qualified if they:   * Are registered with CQC , where a regulated activity is being provided[[9]](#footnote-10) and licensed by Monitor (from 2013) where required, or meet equivalent assurance requirements3 * Will meet the Terms and Conditions of the NHS Standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law * Accept NHS prices * Can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and * Reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols |
| **Quality Incentive Payment** | Means a payment due to the Provider for having met the goals set out in the Quality Incentive Scheme. |
| **Quality Incentive Scheme** | Means any performance incentive scheme set out in Section 4 of Module B of the Contract. |
| **Referral Management Service** | Many PCTs have set up referral management services to act as a collection point for referrals before they are forwarded to secondary care. Different models have been developed: some act purely as information gathering centres, others clinically assess and triage referrals eg clinical assessment centres.  The key is that these services concentrate on working with primary and secondary care clinicians so they have the information necessary to make high quality, consistent referrals[[10]](#footnote-11). |
| **Referral** | This is the process for entry to an appropriate service. It usually requires information to be provided in a format that gives sufficient information to triage the individual.  Referrals can be made by the individual (self-referral) or by a referrer on behalf of the individual |
| **Referrer** | Means:   * The NHS Body that refers a service user to the provider for assessment and /or treatment. * The service user’s GP * Any organisation, legal person or other entity which is permitted or appropriately authorised in accordance with the Law to refer the service user for assessment and/or treatment by the Provider. * Any individual service user who presents directly to the Provider for assessment and/or treatment if self-referral is included within the service specifications. |
| **Service manager** | Responsible for overall service delivery including, but not limited to:  Ensuring a high quality of clinical practice by all practitioners within the service, including necessary supervision of more inexperienced or junior staff  That all staff, including subcontractors, meet the requirements as set out in the service specification and the NHS Terms & Conditions |
| **Service User** | Means a patient, service user, client or customer of a Commissioner or any patient, service user, client or customer who is referred or presented to the Provider or otherwise receives services under this Agreement. |
| **Specifications** | Means the service requirements set out in the service specifications. |
| **Staff** | Means all persons (whether clinical or non-clinical) employed or engaged by the Provider (including volunteers, agency, locums, casual or seconded personnel) in the provision of the Services or any activity related to, or connected with the provision of the Services. |
| **Triage** | This is the process of prioritising people for assessment and/or treatment according to the seriousness of their condition or injury. Using the information provided in the referral form, or via additional contact with the individual or the person who referred them. |

1. Department of Health; 2011; Operational Guidance to the NHS: Extending Patient Choice of Provider. [↑](#footnote-ref-2)
2. Department of Health; accessed November 2011; [www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH\_4100563](http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100563) [↑](#footnote-ref-3)
3. There may be several indicators for each goal [↑](#footnote-ref-4)
4. Department of Health; 2011; Operational Guidance to the NHS**:** *Extending Patient Choice of Provider.* [↑](#footnote-ref-5)
5. Department of Health; accessed November 2011; [www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH\_4100563](http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100563) [↑](#footnote-ref-6)
6. Department of Health, 2008; accessed December 2011. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443> [↑](#footnote-ref-7)
7. Source: <http://www.datadictionary.nhs.uk> accessed 09.10.2010 [↑](#footnote-ref-8)
8. Department of Health; 2011; **Operational Guidance to the NHS:** *Extending Patient Choice of Provider.* [↑](#footnote-ref-9)
9. http://www.cqc.org.uk/sites/default/files/media/documents/8798-cqc-the\_scope\_of\_registration\_revised.pdf [↑](#footnote-ref-10)
10. Adapted from, NHS institute for innovation <http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/demand_and_capacity_-_demand_management.html> [↑](#footnote-ref-11)