APPENDIX A

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	
Service	District Nursing
Commissioner Lead	Stephen Astles
Provider Lead	
Period	
Date of Review	December 2015

1 Population Needs

The purpose of the District Nursing Service is to provide nursing care and support to patients in their place of residence or patients in an appropriate community setting. This will involve developing an individualised care plan relevant to the patient that will encourage patients and carers to play an active role in their care. The service is for adults 16 years and over with a physical need for the District Nurse Service.

- To encourage patients/carers to adopt a healthy lifestyle and promoting self care
- To assess, plan and provide high quality, individualised care
- To provide a seamless service with other health professional and statutory/non statutory agencies
- To prevent unnecessary hospital admissions
- To enable individuals with long term health conditions to achieve quality of life and independence
- To prevent unnecessary GP appointments and home visits
- To provide signposting to health and social care services as appropriate

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

2.2 Local defined outcomes

The service will work within the integrated Virtual Ward team.

Services will be provided either within the patient's home or a community base within their locality.

Appointments will be offered on a timeslot or drop in basis.

The patients practice will be informed of clinical interventions.

Prescriptions required will within the first instance be via Nurse Prescriber, PGD or discussed with patients GP.

All referrals must be dealt with in a clinically acceptable timescale.

District Nurse Team Leaders have assessment skills and are able to prescribe and to mobilise care programmes which enable the service to provide complete episodes of care referring to GPs and health professionals as appropriate.

3 Scope

3.1 Aims and objectives of service

- To provide an identified health professional to assess, manage and monitor an individual patient care management programme
- To provide nursing interventions to the agreed care plan
- To actively promote self care management, maximising independence where appropriate
- To contribute to seamless care, strengthening a whole systems approach
- To prevent unnecessary GP appointments and home visits
- To support end of life care for patients and carers

3.2 Population covered

All patients registered with a South Sefton GP

3.3 Any acceptance and exclusion criteria and thresholds

Patients under the age of 16

3.4 Interdependence with other services/providers

Must link and interact with all community general and specialised services

4 Applicable Service Standards

There is an expectation that the provider will adhere to all national, regional, local multi-agency: legislation, policy, procedures, best practice and internal policies relating to adult and children safe-guarding.

Information Recording and IM&T Requirements

Referrals into the service should be processed electronically. To facilitate this, providers must be Choose & Book compliant, or working towards compliance. Initial appointments must be directly or indirectly bookable through Choose & Book.

Across North Mersey the main strategic system in use across primary and community care is EMIS Web. The EMIS Web clinical system facilitates the capture of clinical interactions (e.g. caseload management, clinical assessment, patient consultation and care planning), clinical decision making at the point of care for primary care GP clinicians and a variety of community based services whilst also enabling full integration of Multi-disciplinary Teams (MDTs).

The iLINKS information sharing framework has been designed and developed to provide a structured framework to facilitate information sharing, ranging from basic demographics and summary information sharing, through to access for practitioners to view full electronic health and social care records. The model is based upon roles and service profiles of practitioners, with specified roles and services having access to a defined set of information based on need and risk. All providers of health and social care across the North Mersey region must sign up to and deliver all principles set out in the North Mersey Information Sharing Framework.

A messaging hub (Medical Interoperable Gateway) is in use across the Health Economy and it is expected that where relevant, this is used for standardised clinical documents to be sent in a timely manner.

The provider must ensure that they comply with the Good Practice Guidelines for Electronic Health Records and that they have all the necessary systems and processes in place to comply with all NHS information governance requirements.

Providers must ensure that the storage of medical records and information which is relevant to treatment and on-going care is passed between all parties in accordance with Caldicott Principles (1997, 2003) and the Data Protection Act (1998).

In addition the provider should also;

- Ensure that service provider activity, performance data and clinical audit will be extracted electronically from the clinical system
- Ensure that all members of staff are adequately trained in the use of the relevant information systems.
- Have robust business continuity with regard to their IM&T systems to ensure that services are not affected and to safeguard information.
- Ensure that patient records are transferable in the case of the provider ceasing to provide NHS services or in the case of the patient changing to another provider. This preferably should be done electronically.

4.1 Equality & Diversity

- To collect and act upon/analyse patient experience data and seek views from relevant protected and vulnerable groups and need to demonstrate how this supports service improvements. This could form part of the eq5d contract monitoring KPI and could form part of the role of EPEG – Jan 2016.
- To be cognisant of their statutory duties to involve, consultant and meet the relevant Equality Duties if the provider proposes further changes to service delivery. The commissioner will need to be notified of changes and have assurances that changes to delivery and done in line with these statutory requirements. The equality Assessment needs to form part of the future discussions when changes to care models are discussed between providers and commissioners – Post April 2016.

5 Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

5.2 Applicable CQUIN goals (See Schedule 4E)

6 Location of Provider Premises

The Provider's Premises are located at:

7 Individual Service User Placement