NHS
South Sefton
Clinical Commissioning Group

Our ref: FOI ID 5544

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NHS South Sefton CCG
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Re: Freedom of Information Request

Please find below the response to your recent Freedom of Information request regarding Continence Services within NHS South Sefton CCG.

Request/Response:

1. What is the population size covered by your community continence service provider?

   156,000

2. Please provide a copy of your community provider continence service specification.

   Please see attached specification

3. Does your provide incontinence pads to patients, or do they assess patients and advise which products the patient needs to purchase?

4. If your provider does provide incontinence pads, is there a limit to how many they are prescribed? If so how many are they allocated?

5. How many weeks supply of pads do patients get at a time?

6. What is the average number of pads prescribed to each patient per day?

7. How often are patient's continence requirements reviewed?

8. How many pads does your provider prescribe a year, for the last full year of data that is available.

9. What is the average daily cost of a patient within the continence service?

10. Please confirm the percentage of the continence patient case load that are prescribed pads due to mobility issues rather than incontinence?

11. Do you provide products for CHC patients in nursing homes, or would this be included in their CHC package of care?

12. Could you please share any prices of products that you may have available?

13. What is the overall cost of your community continence service for the last year available? Please then split this into the amount spent on products, and the amount spent on service delivery.

    £1.15m. For further details please re-direct your request to the provider.

With regards to questions 3 – 12 NHS South Sefton CCG does not hold this information. Please re-direct your request to the provider

Southport and Formby Hospital NHS Trust

soh-tr.foi@nhs.net

SERVICE SPECIFICATION

Service	Continence and Urology Service
Commissioner Lead	
Provider Lead	Carmel Fraser
Period	2009-2012 Contract- Part of Provider Services Block Contract

1. Purpose

The purpose of the Continence and Urology Service is to provide clinical assessment, diagnosis, treatment, ongoing advice and support, review and where appropriate provision of products to adult patients with urological and bowel problems. This is delivered according to individual needs to provide management due to long term conditions, to promote independence and to improve quality of life. The service is provided to patients in a variety of community settings which may be in patients own homes, residential and nursing homes. The service also provides practical advice and support to patients' families and carers.

1.1 Aims

The aims of the service are to provide equitable, safe, cost-effective, evidence-based care to Sefton residents who present with a urological or bowel problem. The service also provides up-to-date training for staff which includes raising awareness of management of the condition **(pathway)**. In addition the service hosts the home delivery service which when appropriate is responsible for the provision of the continence and urology products to adult patients with urology and bowel problems.

It is anticipated that patients and their families will be fully involved in the care management and receive information reflecting how their needs are met. This information is recorded on individual care plans, this documentation is standardised. Information is also provided to patients which can be on amended on review. The patient can share this information with others.

Children's Services provide an assessment service to patients under the age of 18.

1.2 Evidence Base

All Specialist Nurses and Healthcare Assistants, within the Continence and Urology Service work to the professional codes of conduct and standards as set out by the Nursing and Midwifery Council.

They also work in accordance with Department of Health (DH) National Service Framework (NSF)'s, National Clinical Guidelines and Policy documents, and National Institute for Health and Clinical Excellence (NICE) Guidance.
NSF'S:

- NSF for Older People (DH, 2001)
- NSF for Longer Term Conditions (DH, 2005)

NICE Clinical Guidelines and guidance:

- Good Practice in Continence (DoH, 2000)
- NICE Clinical Guideline CG40 Urinary Continence in Women (NICE, 2006)
- NICE Clinical Guideline CG49 Faecal Incontinence in Adults (NICE, 2004)
- NICE Clinical Guideline CG40 Lower Urinary Tract Symptoms in men (NICE, 2010)

1.3 General Overview

These services have been developing for many years, driven by policy directives. The policy document Our Health, Our Care, Our Say (DH, 2006) emphasized the government's drive to refocus health and social care within the community. The key messages included shifting care closer to people's homes to support independence, treating people more efficiently and responding to their needs and expectations. This policy document builds upon the themes set out in the documents Saving Lives: Our Healthier Nation (DH, 1999), The NHS Plan (DH, 2000), The NHS Improvement Plan (2004) and Creating a patient-led NHS (2005). Good Practice in Continence Service Document (DoH, 2000) states that within the population special groups exist who may be affected by urology and continence problems which continence services must address in order to provide best practice.

These services are evidenced based committed to extending, applying, evaluating and reviewing the evidence that underpins and informs it practices and delivery. All nursing has a health promotion component.

User satisfaction, case studies, local engagement and information from support groups also adds to our ability to understand local need and how to improve services on a year on year basis.

1.4 Objectives

Objectives of service:

1. To provide consistently high quality assessment, diagnosis and management of adult patients with urological and bowel problems registered with a Sefton GP.
2. To work in partnership with Multidisciplinary Team colleagues within the Community Teams to provide an integrated, holistic approach to patients' overall management.
3. To provide specialist assessment, advice and follow-up treatment where appropriate for adults with urological and bowel problems.
4. To develop Individual patient-centred goals in collaboration with the patients and when appropriate their families and carers.
5. To maintain effective communication with primary and secondary care to provide a seamless transfer of care for patients.
6. To provide a case management approach for patients working in partnership with Community Matrons etc, preventing hospital admissions.
7. To ensure effective working with other agencies including Care Agencies and voluntary agencies.

1.5 Expected Outcomes

Qualified specialist nurses and Healthcare assistants work to optimise patient independence and quality of life and to minimise the adverse effects of residual difficulties. Prioritising with our patients, we aim to improve:

- The ability to carry out functional activities which promote independence and well-being.
- Participation in occupational, family, social and community activities and networks.
- Quality of life from the point of view of the individual

Also:

- Provision and implementation of bladder and bowel training regimens
- Involvement in case conferences

As a result of the patient experience projects the service has recognised the need to give clear timeframes and goals/outcomes to patients at the onset of care. Also, recommendations are made following any complaints to the service or any incidents related to the service that occurs to improve patient experience.

2. Scope

2.1 Service Description

The service provides clinical assessment, diagnosis, treatment, ongoing advice, support and provision of products to patients with urological and bowel problems. Individual patient-centred goals are developed by the nurses in partnership with the patients and their families and carers. Referrals are accepted from all members of the multidisciplinary team, and patients can also self refer**.** The service is provided in a variety of community settings based on the needs of the patients. This may be in patients own homes, residential and nursing homes**.**

In addition the service hosts the home delivery service which when appropriate is responsible for the provision of the continence and urology products to adult patients with urology and bowel problems. The continence and urology serviced have developed to ensure patients are clinically assessed by qualified specialist nurses to prescribe urology and continence products which are delivered straight from the manufacturer via the home delivery service. Qualified nursing staff from within the community teams can clinically assess patients and prescribe urology and continence products via the home delivery service.

The service currently provides specialist training and support to the Community Teams and to residential and nursing home staff may access this support. This training includes raising awareness of management of the condition (**pathway).**

The service also provides advice and support to patient's families and carers.

Direct Intervention:

- Assessment, diagnosis, therapeutic intervention and management and advice
- Advice to patients, carers and professional colleagues via telephone or face to face contact
- Health promotion advice and signposting to relevant services.
- Provision of urology and continence products where appropriate

Indirect Intervention

- Through understanding patients needs teaching bladder and bowel training regimes
- Case conferences with multidisciplinary and multi-agency colleagues

2.2 Accessibility/acceptability

These services are committed to provide an accessible service to all residents regardless of age and

has adapted to the changing population within Sefton. This is achieved by ensuring regular monitoring of the demographics of individuals accessing the service and developing systems to ensure that there is patient involvement in service development. For example service appointment letters and information leaflets have been adapted in line with the applicants' age, disability and nationality.

2.3 Whole System Relationships

- Work closely with Acute Trust multidisciplinary team colleagues to co-ordinate transition from hospital to community on discharge and seamless transfer of care in particular neurological services, cancer services and gastrointestinal services and medicines management.
- Work in partnership with other agencies particularly care agencies, social services and voluntary agencies.
- Incorporate health promotion providing education and support to help patients make life changes to optimise health and signposting on to relevant services e.g. smoking cessation, physical activity, alcohol awareness, counselling, sexual health, dietetics.

2.4 Interdependencies

- Southport and Ormskirk Trust, University Hospital Aintree,
- General Practitioners and other Primary Care colleagues.
- Nursing and Community matrons
- Colleagues within other agencies including care agencies, social services
- Infection control colleagues

2.5 Relevant networks and screening programmes

- North West Continence and Urology Procurement Group

In order to ensure advance equality of opportunity the service works with various user groups such as:

- ABILITY
- Local Involvement Network (LINk's)

2.6 Sub-contractors

Continence

- Home Delivery through NHS logistics

Urology

- Coloplast

3. Service Delivery

3.1 Service model

The core pathway includes the following stages

1. Referral management
2. Triage
3. Face to Face clinical assessment
4. Diagnostics

5. Treatment including prescription of urology or continence products
6. Review
7. Discharge
8. Feedback to referrer

These steps do not have to follow a numerical order and the need for 3, 4, and 5 will vary for each patient.

Mandatory training underpins best practice including equality and diversity. This supports the ways in which we evidence that services are accessible e.g. public information and reasonable adjustments made. Also, services are adjusted to meet the needs of people with protected characteristics e.g. race, disability, sexuality etc.

The team includes qualified nurses and healthcare assistants with a range of core skills and specialities.

In order to meet the needs of the protected characteristics i.e. Disability and Age the core skills of the staff are:

Qualified Nurses will have core skills/competencies:

- Recognised Nursing Degree or diploma or equivalent
- Registration with the Nursing and Midwifery Council for Licence to Practice and adherence to the minimum practice standards
- As a member of the profession nurses are bound by the Nursing and Midwifery Council Code of Conduct **(expand or clarify)**
- Evidence of post-registration experiential learning within various specialities under direct supervision of nursing staff.
- Understanding of issues with vulnerable children and adults; and awareness of procedures for safeguarding children and adults and other relevant mandatory training
- Ability to work as an autonomous practitioner
- Keyboard and basic word processing skills, e mail, internet and file management

Healthcare Assistants will have core skills/competencies:

- Qualification relevant to working with adults within health and social care (NVQ II or Ill) or equivalent informal qualifications, gained through in-service training, short courses and work experience
- Experience gained by working within a hospital, day hospital or clinic or other relevant person centred setting as part of a nursing service with knowledge of interventions
- Understanding of issues with vulnerable children and adults and awareness of procedures for safeguarding children and adults
- Keyboard and basic word processing skills, e mail, internet and file management

3.2 Care Pathways

(add in continence and urology pathway)

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Sefton, Merseyside.

4.2 Location(s) of Service Delivery

Poulton Road Clinic
Southport
PR9 7BW

Optoplast,
2a Old Racecourse Road
Maghull
L318AW

4.3 Days/Hours of operation

Monday to Friday 08:30-17:00. This service does not operate on bank holidays. This service currently operates within these hours. Work will be ongoing to establish if there is a demand for the service outside of these hours.

The service also operates clinics at various community locations to meet the needs of the local population.

4.4 Referral criteria & sources

Referral is open to health care professionals, multidisciplinary team members, family, friends, carers, and advocates. The patient's consent to referral is required regardless of the source of referral. Patients are able to self refer to this service by contacting the team. All new referrals are reviewed on a **daily** basis by a member of the team.

Referrals will be generally accepted from:

- Patient
- General Practitioners
- Hospital consultants for relevant outpatient referrals
- district nurses, community matrons

4.5 Referral route

All appropriate referrals will be accepted by telephone, fax or written referral form, which will include presenting problems, **past medical history, social history, medication** and any risk factors. The patient's consent to referral is required regardless of the source of referral. All new referrals are reviewed on a **daily** basis by qualified member of the team.

Referrals received that are out of area or that require a different service are referred on to the appropriate service unless urgent in which case the same day. Referrals may be made to relevant voluntary service and support groups with the patient's agreement.

4.6 Exclusion criteria

4.7 Response time & detail and prioritisation

<u>Priority 1</u> Within 5 working days (this is an example from another service can you amend as appropriate)

- **Recent or awaiting discharge from Hospital.**
- **Palliative Care.**
- **Acute tissue viability problems.**
- **Deteriorating complex posture.**

<u>Priority 2</u> Within 8 weeks

- **Individuals who are not at immediate risk but a risk may develop without early intervention.**
- **Individuals who will deteriorate without timely intervention.**

5. Discharge Criteria & Planning

Discharge criteria are considered to be met when:

- **The patient is still making improvements but these gains will continue to be achieved by the patient him/herself. This is considered to be the optimum discharge condition as it further promotes autonomy, engagement, self-direction, independence and choice.**
- **The patient informs the service that they wish to be discharged.**
- **The patients needs are being met.**
- **The patient is no longer benefiting from the intervention. This may be because the patient has reached their optimum potential.**
- **The patient's needs are better met by another service and satisfactory arrangements for transfer to such a service have been made.**

On completion of care or referral on to another service the patient is discharged with clear information of contact numbers if concerned.

6. Self-Care and Patient and Carer Information

On receipt of referral, letter sent to client advising that referral has been received and that appointment will follow. Appointment letter sent advising date time and venue of assessment. Information leaflet and appointment cards are given to the patients. This is provided on accessible formats and with assistance of an advocate, carer or translator is needed.

7. Quality and Performance Standards

Quality Performance Indicator	*Threshold*	*Method of measurement*	*Consequence of breach*	*Report Due*

Infection Control				
Service User Experience		Patient Survey	Unable to utilise feedback to improve the service	
Improving Service Users & Carers Experience		Patient Survey	Unable to utilise feedback to improve the service	
Unplanned admissions				
Reducing Inequalities	Across all protected characteristics	Patient Survey and recording of required data items via existing sources and new processes.	Failure to give assurance on meeting the requirements of single equality legislation	
Reducing Barriers	Across all protected characteristics	Patient Survey and recording of required data items via existing sources and new processes.	Failure to give assurance on meeting the requirements of single equality legislation	
Improving Productivity				
Access	Across all protected characteristics	Patient Survey and recording of required data items via existing sources and new processes.	Failure to give assurance on meeting the requirements of single equality legislation	
Care Management				
Outcomes				
Additional Measures for Block Contracts:-				
Staff turnover rates		Workforce development reports Monthly		
Sickness levels		Workforce development reports Monthly		
Agency and bank spend		Workforce development reports Monthly Finance reports		
Contacts per FTE				

8. Activity

Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*	*Report Due*
Referrals		Part of the monthly data set to be provided to commissioner		
Contacts		Part of the monthly data set to be provided to commissioner		
Outpatients		Part of the monthly data set to be provided to commissioner		

Activity Plan
Based on 2010/11 forecast outturn

Total
Referrals=2916
Contacts=2719
Outpatients=780

2010/11 plans
Continence- North
Referrals= 1429
Contacts= 1333
Outpatients= 382

None of existing service transferring to South however service in the North will provide a service across all Sefton.

2010/11 Plans
Continence- South
Referrals=1487
Contacts=1386
Outpatients=398

9. Continual Service Improvement Plan

User satisfaction, complaints, engagement, focus groups, case studies are all ways to collect both qualitative and quantitative information that informs year on year service improvement.

10. Prices & Costs

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block/cost &volume/cost per case/Other_____*		£		£
Total		£		£

delete as appropriate

10.2 Cost of Service by commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£