1. Population Needs

1.1 National/ local context and evidence base

The Department of Health estimates that there are at least 15 million people who have a long term condition. Additionally, it is estimated that 57% of those over 85 years of age are in contact with a district nurse, there will be a 31% increase in people over the age of 85 in the next ten years. (Department of Health, 2009).

The development of integrated services is a key theme within the Health and Social Care Bill, which was introduced into parliament in January 2011. [http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm)

A ‘listening exercise’ around the Health and Social Care Bill was overseen by the NHS Future Forum, led by Professor Steve Field. The Future Forum has highlighted the existing fragmented nature of the health care system, identified potential barriers to service integration and made key recommendations for amendments to the Bill. One of these was that competition should be ‘a tool for supporting choice, promoting integration and improving quality’ and not an ends in itself. Commissioners will need to address this when considering the relationship between promoting patient choice and incentivising integration when commissioning services. The Future Forum report to government also said that ‘Better integration of commissioning across health and social care should be the ambition for all local areas.’ (See: [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127540.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127540.pdf) for the Future Forum’s initial recommendations).

Input from Think Tanks such as King’s Fund and the Nuffield Trust has contributed significantly to the listening exercise and continues to fuel the national debate around the development of service integration and the importance of collaboration between different providers and different agencies.

The importance of strengthening the commissioning of services, improving integration of services focusing on outcomes, and focusing on improving patient experience were all reflected in the 2012/2013 NHS Outcomes Framework and NHS Operating Framework.

The NHS Operating Framework for 2012/2013 was published on 30th November 2011. It includes guidance on the development of integrate services, specifically including the following points (the
The Operating Framework emphasises patient experience as ‘the final arbiter in everything the NHS does’ (2.27) and states the vital role of complaints handling, learning from mistakes, and seeking out and responding to feedback. Accordingly a significant proportion of the sample outcomes measures detailed in Appendix 1 are centred on patient experience and perception as being a valid measure of success. This further reflects the guidance in section 2.28 of the Operating Framework, which states that in addition to national patient experience surveys, ‘we shall expect each local organisation to carry out more frequent local patient experience surveys’. Section 2.29 states that ‘Commissioners should also look to identify local measures of integrated care that will support improved delivery such as patient reported experience of co-ordinated care’. Goals 4 and 5 within the KPI toolkit (Appendix 1) have been included in order to reflect this indicator.


This outcomes framework describes goals and improvement areas under five key domains.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preventing people from dying prematurely;</td>
</tr>
<tr>
<td>2</td>
<td>Enhancing quality of life for people with long-term conditions;</td>
</tr>
<tr>
<td>3</td>
<td>Helping people to recover from episodes of ill health or following injury;</td>
</tr>
<tr>
<td>4</td>
<td>Ensuring that people have a positive experience of care; and</td>
</tr>
<tr>
<td>5</td>
<td>Treating and caring for people in a safe environment; and protecting them from avoidable harm.</td>
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The goals which have fed into the suggested outcome indicators for integrated care

**Indicators for Quality Improvement (IQIs).**

The NHS Information Centre provides a national collection of indicators designed to support the measurement of quality improvement (IQIs). These were developed from 2008 onwards and include QOF, Vital signs, and Community indicators which were developed as part of the Transforming Community Services Programme, which ended in 2011. The indicators are accessible at https://mqi.ic.nhs.uk/. Goals which have informed the development of the sample indicator set produced include:

PE15 Score for patients who reported that the ‘right amount’ of information about conditions/treatment was given by healthcare professionals

PE16 Score for patients who reported that they were involved as much as they wanted to be in decisions about their care and treatment

**Long term conditions**

‘Supporting the better management of Long Term Conditions (LTCs)’ is a QIPP worsktream, which is led by Sir John Oldham. Further details can be found at http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115448

Improved self management- supporting people to manage their own conditions- is an important goal within the NHS outcomes framework and as such an important goal for an integrated care service. IPOS Mori, in a research study commissioned by the Department of Health, found that the top three
issues that people felt would support them in self-managing their long term condition included:

- Information about the long term condition (20%)
- Information about the treatment (17%)
- Information about how to prevent the worsening of a long term condition or to prevent accidents (16%).


1.2 National evidence base and points of debate

A number of the challenges inherent in developing an integrated approach have been explored through analyses and publications from the King’s Fund and the Nuffield Trust. See Appendix 2 for a full bibliography. Some of the key debates and evidence summaries are outlined below.

Curry and Ham (2010) produced an in depth overview of the types of integration and the forms that it might take, drawing on international examples. (see http://www.kingsfund.org.uk/go.rm?id=21648). They emphasise that integration cannot be approached as a ‘one size fits all’ and must be tailored around to the needs of the patient population. The concern around the current fragmentation of the system is that it creates the risk of people ‘falling through the gaps’ in service delivery.

1.2.1 Definitions of Integration

Curry and Ham (2010) distinguish between three different types of integration:

- Macro level (single organisation delivering a whole spectrum of health services for a population),
- Meso level (integration of services for patients with specific conditions) and
- Micro level (co-ordination for individual patients).

They also distinguish between horizontal integration (when service providers delivering services at the same level, for example community health and social care work together) and vertical integration (between community, acute, and tertiary providers), and between ‘real’ integration (where provider organisations merge to create a single with shared budgets) and ‘virtual’ or ‘contractual’ organisation, where a network of providers work in collaboration with each other, often supported through a contractual arrangement.

Griffiths and Smith (2011), in a presentation published by the Kings Fund, discuss the different ways in which integration can be thought of. They describe integration as ‘the combination of processes, methods and tools that facilitate integrated care’ and integrated care as something which results when ‘the culmination of these processes directly benefits communities, patients or service users’. They suggest that integrated care may be considered successful if it contributes to improved experiences, improved outcomes, or improved cost effectiveness. (http://www.kingsfund.org.uk/current_projects/integrated_care/integrated_care_work.html).

1.2.2 Competition and integration

An article published by the King’s Fund, ‘Can competition and integration co-exist within a reformed NHS’ (Hawkins, July 2011) addresses some of the challenges that are inherent to promoting the government directives (as outlined in the Health and Social Care Bill) to introducing competition into the marketplace whilst at the same time trying to incentivise integration between providers.

It references Ham and Smith (2010)’s work on the pilot Integrated Care Organisations (ICOs) which identified perverse incentives and procedural barriers to integration. These include (among other issues):
• Payment by results
• Divestment of Community Services from PCTs.

The paper as a whole discusses examples of the relationship between competition and integration. It distinguishes between competition within the market and competition for the market.

Competition for the market:
- Hawkins describes this as being where commissioners contract a single provider or a limited menu of providers to deliver services for a defined patient population.

Competition within the market
- Hawkins describes this as patient and referring doctors choosing from a limited menu of providers - as is intended within the ‘any qualified provider’ model. This is viewed (by Hawkins) as having limitations as the existing PbR system offers little reward for co-ordinating patient care across episodes.

Competition for the market is advocated by Hawkins. Page 5 of the article onwards explores the idea that commissioners could contract a ‘lead provider’ to deliver care for the whole pathway, with the payment covering all providers involved – and that patients could be offered a choice of integrated providers for a whole pathway.

This would involve vertical integration between community and secondary care. It is advocated within the paper as it would mean that innovative ways of delivering care could be financed through the comparative security of a ‘lead provider’ contract. The ‘Any Qualified Provider’ model is viewed as being more risky.

The paper points to the limitations of the existing tariff system in fostering collaboration, and suggests that clinical commissioning groups will be able to foster integration through their procurement practices where they are commissioning non-tariff services (e.g. community services) but that increasing use of tariffs beyond the acute sector may limit this.

It advocates the development of ‘bundled provider payment currencies’ to support ‘competition for the market’, and points to the importance of incentivising vertical (secondary/community) integration.

These are issues which need to be considered in developing an integrated care service specification. Where integration is horizontal (between community health care providers and social care), commissioners need to consider how performance targets and incentives work in synchrony with each other. Cambridgeshire Community Services, who operate numerous integrated services, have talked about the challenges inherent in ‘serving two masters’. Equally, where integration is vertical (between community and acute providers providing treatment for the same condition, the questions of how outcome goals (and, indeed, incentives) interrelate across a care pathway will need to be considered.

Incentivising good outcomes, and incentivising integration, is a subject of ongoing national debate active debate. The King’s Fund is hosting a conference around this topic on January 10th 2012 (http://www.kingsfund.org.uk/events/incentivising.html ), and further publications and presentations are expected to be available via the King’s Fund website subsequent to that date.

1.2.3 The evidence base for integrated care

As outlined in 1.2.1, a presentation by Nick Griffiths and Judith Smith (2011) summarises some of the current thinking around the evidence base for integrated care.

It emphasises that concerns about service integration date from the start of the NHS, and also points to the different meanings that are applied to the notion of integration.

Griffiths and Smith point to evidence from cross-cultural examples that integration is most effective when it is targeted towards people with severe, complex and long-term needs. They suggest it is best suited to frail older people, those with long-term chronic and mental health illnesses, and those requiring urgent care. They suggest that it is most effective when it is population based and approaches the holistic needs of a patient, rather than condition based. They suggest that condition-
based approaches to integration can create silos and thus lead to different types of fragmentation.

Positive examples of integration from the UK cited by Griffiths and Smith include:
- Torbay Care Trust
- North Somerset Partnership for Older People Project
- Diabetes care in Bolton
- Rheumatology Care in Oldham
- Chronic Care Management in Wales
- Stroke Care in London
- Bolton's urgent care dashboard
- Liverpool Care Pathway

Regional examples (from the NHS Midlands and East) cited include the Cambridge ICO pilot, and Hereford's integrated care organisation.

The Cambridge ICO pilot sought to establish a model of integrated services around end-of-life care. Details can be found at http://group.assuragroup.co.uk/new-pilot-scheme-to-improve-end-of-life-care-for-cambridgeshire-patients.aspx

Hereford has carried out ‘real’ integration between community and acute care and social care, to create Wye Valley NHS trust. More details about the programme can be found at http://www.herefordshire.nhs.uk/1480.aspx and at http://www.wyevalley.nhs.uk/.

Griffiths and Smith’s presentation includes a discussion on the organisational, management, and policy barriers around the development of integration, some of which focus on the balance between establishing a relationship between collaboration and competition. They also emphasise, based on national and international examples, that integration does not evolve naturally, but needs to be nurtured, through systemic leadership, and good management. The role of good data and IT is also considered.

1.2.4 Torbay Mrs Smith model

The work carried out in Torbay, who in 2005 created a Care Trust with pooled budgets between health and social care which included five joint health and social care teams are cited by Curry and Ham (2010) as good example of meso-level horizontal integration, as it represented integration between services that were delivering care to a specific population.

The Torbay model focused on improving care for ‘Mrs Smith’, a fictional 85 year old user of services, who had multiple long term conditions and high social care needs. The integrated teams included ‘health and social care co-ordinators’ to act as a single point of reference. The aim of the service was to provide a more seamless experience for Mrs Smith, to ensure she did not have to repeat the same information twice, and to ensure information about her needs was appropriately shared between those providing her with care.

Peter Thistlethwaite, produced a more in depth discussion of the Torbay model, entitled ‘Integrating Health and Social Care in Torbay’; improving care for Mrs Smith’ (published by the King’s Fund, 2011, http://www.kingsfund.org.uk/go.rm?id=21956). Evidence has suggested that the adoption of an integrated approach reduced the emergency bed and improved service user satisfaction (Curry and Ham, 2010).

The ‘Mrs Smith’ model has been adapted as supporting material for this sample specification. Appendices 3 and 4 include examples around how one might plan for good outcomes for a fictional service user, ‘Mrs Jones’, who has a leg ulcer and multiple co-morbidities. The aim of these examples is to support thinking around commissioning of services by exploring the relationship between activities and outcomes, and what might constitute a good outcome for ‘Mrs Jones’ in the example, and how those outcomes might be quantified and described in terms of measurable outcomes and goals. Significantly, it puts the needs of the service user at the heart of the commissioning process, and places Mrs Jones’ point of view at the centre of building an understanding of what constitutes a ‘good outcome’.
1.3 National Long Term Conditions Programme

NHS Midlands and East is working with Sir John Oldham on the Long Term Conditions (LTC) national work stream. This programme highlights three key principles around the management of LTCs, including:

1. Risk Profiling
2. Neighbourhood care teams
3. Self Care/Shared Decision Making

NHS Midlands and East advocates the use of risk stratification tools in the delivery of community based services for people with long term conditions. Risk profiling helps to identify those LTC patients who are most likely to be high users of services, and to develop systems and services which are able to manage this demand (source: LTC Workstream programme overview: http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115448). The current DH guidance concerning risk stratification tools can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_129105.

The aim of the workstream is to reduce unscheduled hospital admissions by 20% and to reduce length of stay by 25% by 2013/2014. The provision of effective community services and the use of robust means of identifying which individuals are most at risk of unscheduled hospital admissions are clearly important mechanisms to support the achievement of this goal. Goals 6 and 7 within Appendix 1 reflect these goals. Goal 6 is in need of further refinement, but commissioners are expected to advocate the use of risk stratification tools when commissioning integrated services for people with LTCs.

1.4 NHS Midlands and East Ambitions and Regional Approach

NHS Midlands and East has agreed five key Ambitions regarding service improvement over the coming year. These include:

1. The elimination of grade 2, 3 and 4 pressure ulcers by December 2012
2. Making every contact count
3. To improve quality and safety in primary care
4. Strengthen partnerships between the NHS and local government
5. Create a revolution in patient and customer experience

The Ambitions are relevant to service delivery across sectors. The Ambitions to make every contact count, strengthen partnerships, and create a patient experience revolution are particularly relevant to the provision of integrated care for people with long term conditions.

1.5 Local Context

This section should detail information known concerning the over 65 years of age population and information concerning people with long term conditions, and where possible, information concerning the risk profile of these populations. How the integrated care service specification and goals links to other local service plans, or other initiatives in development, should also be included.
### 2.1 Aims and objectives of service

The aims and objectives of an integrated service fit within the three core QIPP domains of efficiency, effectiveness and patient experience. An integrated care service should also aim to support achievement of the NHS Midlands and East five ambitions.

<table>
<thead>
<tr>
<th>NHS Mid Essex describes the overall aim of their integrated care service as follows:</th>
</tr>
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<tbody>
<tr>
<td><strong>The overall aim of the Integrated Care Teams Service (&quot;ICT&quot;) is to provide excellent healthcare in the community setting to enable local people to improve, maintain, or recover health and prevent ill health or decline. This includes supporting people to cope with their health problems and to achieve the best quality of life and independence possible for the individual patient. This will be achieved through the application of a holistic person centred approach to care that is integrated across professions and settings and embedded within primary care and General Practice.</strong> (Mid Essex ICT Service Specification)</td>
</tr>
</tbody>
</table>

One of the key aims of an integrated care service is to ‘make every contact count’ (as per the NHS Midlands and East Ambitions) through ensuring that contact with professionals supports shared goals around health education, health improvement and prevention of long term conditions or worsening of existing conditions. Strengthen partnerships between the NHS and local government – the NHS Midlands and East ambition 5 – will be an important means by which improved integration of services is achieved.

Page 3 of Appendix 1 maps the relationship between service aims, national improvement areas, and example measurable metrics.
2.2 Service description/ care pathway

A range of examples of services targeted at effecting improvements in the care of older people with long term conditions are available (see section 1.2.3). Development of integrated services continues to be an ongoing process across the region. Cambridge Community Services works with both NHS Cambridgeshire and Cambridgeshire County Council to provide intermediate care services, and a number of LCGs are developing integrated case management teams to assess referrals and care management.

Commissioners are encouraged to refer to existing examples of integrated care when developing their own plans for integrated services, and to share good practice.

The example below is the service description and care pathway from Mid Essex’s Integrated Care Team Service Specification, who have given permission for their work to be shared on a regional basis.

**Service Model**

The ICT is provided by registered nurses, allied health professionals and health care support workers who are appropriately trained, experienced and with competencies and skills that are maintained and kept up to date commensurate with their roles and the requirements of the ICT. The ICT is central to the capability of adults to remain in their own homes, maximise their independence and improve health outcomes and quality of life. The model will offer consistent and rigorous assessment of the urgency of the individual’s care needs and an appropriate response to meet that need.

Each Team will have a highly skilled named Community Matron who clinically leads the Team working closely with the patient’s GP, utilising a systematic approach to anticipate risk, and match care with need through the implementation and co-ordination of single or multiple interventions. Interventions are carried out in patient’s homes, GP surgeries and clinics, day hospitals, residential homes and acute care settings. The Teams must be flexible and responsive enough to offer the appropriate level of intervention and involvement for each person and be able to increase or decrease the intensity of care as health and well-being improves or deteriorates. The following should be seen as part of the Team:

**Those employed by CECS:**
- Community Matron/District Nurses/Community Nursing staff (including Intermediate Care);
- Occupational Therapists and Physiotherapists;
- Admission Avoidance/Urgent Care Response Staff.

**Those not employed by CECS:**
- GPs/Practice Nurses

Strong Partnership working with:
- Mental Health teams and Social Care;
- Community Hospitals;
- Rapid Assessment Unit.
The Provider must ensure that the ICT is provided equitably across localities in response to need particularly in relation to the allocation of resources to ensure that patients have equal access to services which are comparable in terms of quality and responsiveness. Practices and patients in rural areas should not be disadvantaged and should receive the same level of engagement and responsiveness from the Teams.

The Mid Essex model will be based on the following principles:

- Integrated co-located Practice aligned Multidisciplinary Community Teams;
- Partnership working with Social Care, Mental Health, Specialist Nurses and the Voluntary Sector;
- Single point of contact via a Central Administrative Hub;
- Single integrated clinical record which includes the Single Assessment Process;
- Multidisciplinary care planning and patient management;
- All patients with a Long Term Condition to have in place a Personal Health Plan;
- Use of predictive risk tools and risk stratification of patient intervention.

The ICT will reflect the DH Long Term Conditions Strategy (2005) which describes good practice in relation to three levels of care to achieve optimum results for patients and provides the framework on which services should be delivered.

**Level 1: Promoting Self-care**

The Teams shall work with patients, families and carers to support, educate and contribute to a patient’s ability to care for themselves. The Teams will share their skills and knowledge acting as a key resource and providing a route to other services and professionals. Health promotion and prevention will form part of the care plan and patients will be signposted to expert patient and local self-help groups. The Teams shall be responsible for making patients aware of the options available to them to choose from.

**Level 2: Improving Disease Management**

The Teams shall work with patients who have chronic disease requiring specialist clinical interventions to achieve optimum health and reduce the risk of complications and deterioration. GP’s, generalist and specialist nurses and AHP’s will work together to organise care seamlessly across the patient pathway. They will devise and implement protocols, develop review systems and contribute to secondary and tertiary prevention.

**Level 3: Managing Complex Patients**

The Teams led by the Community Matron shall use data and locally agreed criteria to identify patients who are at the highest risk of inappropriate hospital admission. Utilising Case management competencies the Community Matron shall lead and co-ordinate care for a caseload of patients with complex needs. The Community Matron shall combine high level assessment, pharmacological management and anticipatory managed care based on the principles of the least invasive care in the least intensive setting. Patients will be supported to make personal choices about their care, including the decision to stay in their own home until the end of their life.

*(source: NHS Mid Essex Integrated Care Team Specification, 2011)*
The full care pathway descriptions are accessible in the full service specification. A copy can be obtained by contacting Jane Kinniburgh at NHS Mid Essex. It is also available for download at http://www.networks.nhs.uk/nhs-networks/outcome-based-commissioning

2.3 Population covered

Demographic information describing the over-65 population within the area concerned should be inserted here. Any specific information about numbers of older people with long term conditions and any information concerning the number of people with multiple co-morbidities should also be included.
2.4 Any acceptance and exclusion criteria

Acceptance criteria

NHS Midlands and East advocates the use of risk stratification tools to support the targeting of services. Further information on the use of risk stratification tools can be provided by heather.ballard@eoe.nhs.uk or alida.farmer@eoe.nhs.uk. Acceptance criteria should outline the minimum criteria for acceptance, but also how services will be targeted. An example from NHS Mid Essex describe their integrated care team is as follows:

The ICT will ensure that all patients presenting with a healthcare need that can be appropriately & safely managed in the community are accepted for assessment and triage. Referral sources will be via GP/Practice, Team members(District Nurse, AHP, Specialist Nurses, Social Care, etc.) and Secondary Care.

- Patients must be 18 years or over;
- Patients must be registered with a Mid Essex GP;
- Patients must have been assessed as not requiring acute hospital care.

In addition case finding will focus on Long Term Conditions and Complex Care patients selected by using a population based predictive risk model that uses community services information, hospital episode data, GP practice and census data. Tight definitions of 'complex' are undesirable because of the potential to lead to intricate referral criteria that exclude rather than offer an inclusive and proactive model although broadly 'complex' would include the following:

- Four or more active long term conditions;
- Four or more medicines prescribed for six months or more;
- Two or more hospital admissions (not necessarily as an emergency) in the past 12 months;
- Two or more A+E attendances in the past 12 months;
- Significant impairment in one or more major activity involved in daily living;
- Older people in the top 3% of frequent visitors to a GP Practice;
- Older people whose stay in hospital exceeded four weeks in a year;
- Older people whose social work contact exceeded four assessment visits in a three month period;
- Older people whose prescribing costs exceed £100 per month;
- Recent exacerbation or decompensation of chronic illness (within last 90 days);
- Recent falls: > 2 falls in 2 months;
- Recently bereaved and at risk of medical decline (death of a spouse or family member in past 6 months);
- Cognitively impaired, living alone, medically unstable and high intensity social service package.

(source: NHS Mid Essex ICT Service Specification 2011)
Exclusion criteria

Any service exclusion criteria should be inserted here. An example is included below.

The service excludes:

- People that live in Mid Essex but are not registered with a Mid Essex GP;
- People under the age of 18 years;
- Provision of nursing tasks within Nursing Homes or other support that should be provided by the home;
- Core Primary Care provision which is contained within the GP contract and remains the responsibility of Primary care.

(Source: NHS Mid Essex ICT Service Specification 2011)

2.5 Interdependencies with other services

Agencies with whom the integrated service will partner, either through liaison or through contractual linkage, should be detailed here.

The Provider shall ensure strong partnership working with other statutory, voluntary and private agencies to deliver seamless care. The provider shall establish and maintain effective relationships with key stakeholders. The Integrated Care Team will receive referrals from Mid Essex GP’s, Mid Essex Health Care Professionals, and Mid Essex Hospitals Trust. The ICT incorporates integrated working with other community and unscheduled care services including:

- Out of Hours;
- Ambulance Service;
- Social Care;
- Voluntary sector;
- Marie curie;
- Hospices;
- Continuing Health Care Team.

The ICT brings together a number of services aimed at reducing admission to secondary care and as such will need to facilitate and develop robust mechanisms for close joint working to manage an individualised patient pathway and to meet patients and carers needs.

The Teams will work closely with the following stakeholders:

- GPs, Practice Nurses and Practice staff;
- Patients, carers and relatives;
- Hospital Consultants and other medical staff in and outside of the area
- Nurse consultants & specialist nurses within the community and hospital setting
- Acute sector nursing staff;
- A&E staff e.g. nursing, liaison and administrative staff;
- Social Care, including advocacy;
- Local authority housing departments;
- Equipment service;
- Mental health services;
- Drug and alcohol services;
- Counselling services;
- Day centre and care home staff (private & council);
- Ambulance service;
- Voluntary and charity sectors;
- Community pharmacists.

(Source: NHS Mid Essex ICT Service Specification 2011)
2.5.2 A model by which interdependencies between types services, and the relationship between activities and outcomes, can be considered has been outlined in Appendix 3. The Care Delivery Value Chain is a model developed by Porter and Teisberg (2006) and developed further by Kaplan and Porter (2011).

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

The domains within published in the NHS Outcomes Framework relevant to the delivery of integrated services for older people with long term conditions include:

Domain 2: Enhancing quality of life for people with long term condition
Domain 4: Ensuring people have a positive experience of care.

Domain 2 is particularly relevant to the care of older people with long term conditions and the delivery of integrated care. National indicators included within the sample outcomes on page 3 of the KPI framework (Appendix 1) include: Overarching Indicator 2 - Health Related Quality of Life for people with Long term conditions and improvement areas 2.1., 2.3.i., and 2.4.

The NICE Quality standards likely to be relevant to the development of integrated services for older people with long term conditions include:

- Diabetes
- Chronic Obstructive Pulmonary Disease
- COPD

Further relevant national standards (as listed by NHS Mid Essex, now part of the North Essex PCT Cluster, in their integrated care specification) might include:

- National Service Framework for Older People (2001);
- End of Life Strategy Incorporating End of Life tools (DH 2008);
- Compliance with Care Quality Commission standards and guidance;
- Compliance with NSF and NICE recommendations;
- Seven Steps to patient safety (second print 2004);
- Mental Capacity Act (DH 2005);
- Essence of Care Benchmarking ;
- Dignity Challenge (DH 2007);
- Dementia Strategy (DH 2009);
- Supporting People with Long Term Conditions DH (2005);
- Transforming Community Services DH (2009);
- The Health Act 2006: Codes of practice for the prevention and control of Health Care Associated Infections (revised 2008);
- Compliance with appropriate Health and Safety legislation (e.g. HASWA 1974 Act, COSHH, RIDDOR 1995);
- Compliance with alert notices as stipulated by the MHRA (including Equipment Evaluation Project).

(source: Integrated Care Teams service specification, NHS Mid Essex 2011)

3.2 Applicable local standards
This is intended as a non-exhaustive list. Clause 5 takes precedence

See Appendix 1 for specific measurable metrics which can be applied to the service
specification and which have been designed to support local and regional goals.

4. Key Service Outcomes

- An increase in the number of people feeling supported to manage their own conditions
- A reduction in the number of falls experienced by older people
- Reduction in inappropriate unplanned admissions
- Increasing community-based treatment of LTCs
- Ensuring patients have a positive experience of care

See Appendix 1 for examples of measurable metrics which can be applied to an integrated service specification. Metrics shaded in pink are related to national guidance (for example the outcomes framework). Those not shaded are based around regional examples and discussions concerning good practice.

The goal concerning risk stratification is recommended for inclusion following the work done through the long term conditions programme carried out by NHS Midlands and East in led by Sir John Oldham.

CQUIN is also available to incentivise ‘stretch’ targets; 2.5% of the budget can be allocated to this, although 20% of the CQUIN budget must be allocated to nationally mandated CQUIN goals.

NHS Mid Essex has an incentive scheme based around admissions avoidance for people over 65. This is described below.

The Commissioner and Provider have agreed an incentive scheme to recognise the sharing of benefits arising from system-wide QIPP initiatives.

Avoided Emergency Admissions (Over 65s):
- 2011/12 Target for Avoided Admissions 2,369;
- The Provider will be paid £250 per Admission Avoided beyond the defined threshold of 2,087 and will be paid an additional £500 per Admission Avoided beyond the defined threshold of 2,369;
- The Parties agree that there is no incentive cap and that the scheme will operate for all Admissions Avoided above the thresholds defined above. The Commissioner shall undertake a quarterly sample-based audit of records within 15 operational days of the end of the quarter, the results of which will be discussed by the Parties before any amendments to the ‘frozen’ reported position for the quarter are made.

(source: NHS Mid Essex Integrated Care Teams Service Specification 2011)

5. Location of Provider Premises

The Provider’s Premises are located at:

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

6. Individual Service User Placement

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