SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement

Optional heading 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No	TBC by Contracts Team
Service	**Community Parkinson's Disease Specialist Nurse Service**
Commissioner Lead	**South Cheshire Clinical Commissioning Group** **Vale Royal Clinical Commissioning Group** **–** [redacted]
Provider Lead	**University Hospital of North Midlands** **–** [redacted]
Period	**(23rd May 2016 for 1 year period**
Date of Review	**12 months from commencement**

Service Summary

INTERIM spec
This Spec will be an INTERIM spec between 23rd May 2016 and 23rd May 2017; it includes nurse training, development and setting up of Performance/Quality measures, agreeing reporting protocols and the setting up of the SOP.

FINAL Spec
This Spec will be superseded by the FINAL Service spec, which will be issued once the Steering Group has agreed it. It is at that point that UHNM will be required to deliver against agreed performance and quality indicators.

From May 2017, all University Hospital of North Midlands (UHNM) patients registered with a GP in NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups (SCCCG and VRCCG) over the age of 18 years with a confirmed diagnosis of idiopathic Parkinson's Disease or have a Parkinsonian related condition will be able to choose to receive on-going care delivered by a Parkinson Disease Specialist Nurse (PDSN) in a community based service. On receipt of a referral from a UHNM Consultant Neurologist in line with their management care plan agreed between the UHNM Consultant Neurologist, patient and PDSN. The community based service will be accessible to patients registered with a GP practice and under the care of a UHNM Consultant Neurologist.

From October 2017, all patients in NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups with a confirmed diagnosis of idiopathic Parkinson's Disease, or a Parkinsonian related condition, will be able to choose to receive on-going care delivered by a Parkinson Disease Nurse Specialist (PDSN) in a community based service. On receipt of a referral from a Consultant Neurologist from other Hospital Trusts in line with their management care plan agreed between the Consultant Neurologist, patient and PDSN.

Document Version Control

Version Number	Updated by and date	Amendments made (page and type)
1.0	LBP 20/12/12	Commenced Service Specification creation for consultation.

1.1	LBP 11/02/13	Revised layout to incorporate 2013-14 Service Specification requirements.
1.2	LBP 24/5/13	Revised following consultation with patients and providers
2.1	LBP 30/8/13	Revised following consultation with UHNM as provider
2.2	LBP 24/12/2013	Response times reviewed following consultation with UHNM as provider
3.0	SM/GC 26/10/2016	Revised after review at Steering Group meeting
4.0	LF/SM 09/02/2017	Revised after review at Steering Group meeting

Acronyms

CCG	Clinical Commissioning Group
CHC	Continuing Health Care
DH	Department of Health
GP	General Practitioner
MDT	Multi-Disciplinary Team
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OT	Occupational Therapies
PD	Parkinson's Disease
PDSN	Parkinson's Disease Specialist Nurse
PDUK	Parkinson's Disease UK (United Kingdom)
SALT	Speech and Language Therapies
SCCCG	South Cheshire CCG
UHNM	University Hospital North Midlands
VRCCG	Vale Royal CCG

SECTION B PART 1 - SERVICE SPECIFICATIONS

1. Population Needs

1.1 National/Local Context and Evidence Base

The Service model to be developed by the Parkinson's Steering Group and delivered by UHNM will reflect the following guidance and policy documents:

Equity and Excellence : Liberating the NHS (DH 2010)
Implementing Care Closer to Home : Convenient Quality Care for Patients (DH 2007)
Improving Patients' Access to Medicines (DH 2006)
NICE Clinical Guidelines for Parkinson Disease (NICE 2006)
National Service Framework (NSF) for Long term Neurological Conditions (DH 2005)
National Service Framework (NSF) End of Life Care (DH 2005)
Relevant policies and procedures for University Hospital North Midlands (UHNM)

The Service Provider is expected to work with NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups (CCGs) to adapt and strengthen the Service as new guidance and policies are published.

Parkinson's UK has undertaken a vast amount of research to understand the number of people suffering with the Parkinson condition. The research estimates that 1 in every 100 people over the age of 65 will develop

Parkinson`s, this equates to 311 sufferers for South Cheshire Clinical Commissioning Group and 173 sufferers for Vale Royal Clinical Commissioning Group based on current population figures. Further research estimates that of these number 5% of people diagnosed with Parkinson`s will be under the age of 40 equating to 16 for South Cheshire and 9 for Vale Royal. The incidence rate identified for Parkinson's is 17 new cases per 100,000 population every year this equates to 29 new cases a year within South Cheshire and 17 new cases for Vale Royal.

Information provided from the local Parkinson Support Group indicates that 55% of patients currently access a specialist Parkinson Nurse service through University Hospital North Midland (UHNM), or through UHNM clinics at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT). 33% of patients in our area access a similar service outside of the area, e.g. the Walton Centre, Countess of Chester, Salford Royal NHS Foundation Trust etc. Neurology teams

At June 2016 there were approximately 443 patients that have been diagnosed with Parkinson's Disease under the care of UHNM. Patients not seen by UHNM service will be identified through a practice audit in April 2017 to give the full figure for the SCCCG and VRCCG footprint. Of the 443 patients on Consultant lists at UHNM, 280 are in the South Cheshire and 124 are in Vale Royal.

The Parkinson's Disease Specialist Nurse (PDSN) will support patients of SCCCG and VRCCG regardless of which Neurology Consultant waiting list they exist on.

2 Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

The service will support delivery of the 5 domains in the NHS Outcomes Framework as follows:

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

2.2 Local Defined Outcomes

The Community Parkinson Disease Speciality Nurse (PDSN) Service will:

- Support and improve the quality of life for Parkinson's Disease or patients with Parkinsonian related conditions from diagnosis to end of life should this be the patient's choice.
- Bring care closer to home in line with the NHS 5 year forward view.
- Ensure regular timely reviews in line with NICE guidance.
- Work closely with UHNM Neurology Consultants, and UHNM Parkinson's Disease Clinical Nurse Specialists (PDCNS) and local GP practice clinical teams.

3 Scope

3.1 Aims and Objectives of Service

The Community PDSN Service consists of a registered nurse supported by a network of health care professionals that will see SCCCG and VRCCG patients, over the age of 18, in their local area, with a confirmed diagnosis of Parkinson's Disease or Parkinsonism related conditions from a Consultant Neurologist through Community Clinics, telephone contacts and home visits. Initial development in the first year will be driven by the PDSN and the Steering Group, Steering Group Members will be:

Title	Organisation
Service Delivery Manager	NHS South Cheshire and NHS Vale Royal CCGs
Area Development Manager	Parkinson's UK
Directorate Manager (Neurology)	University Hospitals North Midlands NHS Trust
Matron (Neurology)	University Hospitals North Midlands NHS Trust
PDSN (South Cheshire and Vale Royal)	University Hospitals North Midlands NHS Trust

The service will aim to:

- Integrated neurology service for patients who choose to be referred by a Consultant Neurologist with a diagnosis of Parkinson's disease, so care can be delivered closer to home in the community setting.
- Work collaboratively with UHNM Neurology Consultants and UHNM Parkinson disease Clinical Nurse Specialists (CNS) to implement a MDT (Multi-Disciplinary Team) approach to patient care for those with Parkinson's disease or Parkinsonism related conditions that will support patients to remain in their own home wherever possible, reduce exacerbations and complications that can lead to admissions and facilitate a timelier pathway.
- Assist MCHFT ward staff in making appropriate refers to rehabilitation, hospice day care, respite or intermediate care services for patients pertaining to SCCC and VRCCG with a confirmed diagnosis of Parkinson disease or Parkinsonian related conditions from a Consultant Neurologist, to facilitate timely discharges and reducing Delayed Transfers of Care (DTOC).
- Provide high quality, comprehensive, holistic and timely assessment and treatments to patients with a confirmed diagnosis of Parkinson's disease or Parkinsonian related conditions.
- Provide patients, families, carers and healthcare professionals with education sessions to share information, advice to support Parkinson's disease patients in regards to all aspects of promoting self-management/care, independence and to prevent secondary complications.
- The PDSN will work closely with Parkinson's disease UK to continually improve community service using questionnaires, surveys or PALs or complaint trends.

Secretarial and administrative support is funded by the CCGs at £10,000 pa. Overall responsibility for HR requirements, recruitment, line management and professional development will be with UHNM.

3.2 Service Description and Care Pathway

The Community PDSN Service consists of a registered nurse supported by a network of health care professionals that will see SCCCG and VRCCG patients, over the age of 18, in their local area, with a confirmed diagnosis of Parkinson's Disease or Parkinsonism related conditions from a Consultant Neurologist through Community Clinics, telephone contacts and home visits.

In scope:
During the first 12 months the steering group will develop the service as follows

- This Service will be designed for SCCCG and VRCCG GP registered patients with a confirmed diagnosis of Parkinson's from a Consultant Neurologists
- Development of MDT handover and care plan from Secondary Care Consultant/s in Neurology to the PDSN
- From May 2017 the service will begin to take SC/VR patients from a UHNM Consultant Neurologists that would benefit from additional support in the community
- From October 2017 service will take SC/VR patients from the lists of all Consultant Neurologists that would benefit from additional support in the community with full MDT handover and care plan from Secondary Care Consultant/s in Neurology
- Include Community based clinics and patient reviews on appropriate patients from SCCCG and VRCCG who wish to be reviewed in the community setting
- Assist ward visit outcomes for SCCCG and VRCCG patients residing as inpatients at MCHFT
- The service is funded by SCCCG and VRCCG on a block contract for their registered patients only
- The service will be required to demonstrate the impact on the avoidance of acute admissions as outlined in the initial offer from the CCGs to UHNM and through KPIs agreed by the steering group in the first 12 months

- The spec will include Quality visits and/or audits may be undertaken by the CCG

Out of scope:
This is not an emergency service.
- Patients registered in other CCG areas
- Patients without a confirmed diagnosis of Parkinson's disease or Parkinsonian related conditions from a Consultant Neurologist.
- Referrals from GPs, other community services, social care, third sector
- Patients in the early stages of the disease and those that are able to self-care and manage the condition themselves.
- Secondary care consultant led clinics other than Neurology
- PbR

3.2.1 Stage 1: Service initiation and development

The PDSN and Steering Group will be instrumental in the development of the service in year 1, this will include:

The service is funded for the first 2 years (24 months) by Parkinson's UK to enable the lead PDSN recruited to the post to gain training and experience prior to the service going live allowing time for the PDSN to be part of the service development and implementation process with the provider (UHNM) and commissioners.

Throughout the first 2 years the service will evolve as the PDSN patient list is formed through patient referrals these will start in May 2017 from UHNM and October 2017 from multiple specialist trusts. All parties must play an active role to support this development of the service through regular review of the service specification.

Stage 2: Service Implantation

The PDSN and Steering Group will be instrumental in the implementation of the service in years 1 to 2, this will include:

- Approx. 20% of the nurses time in the first and second year will be made available to
  - Attend Parkinson's training and development sessions to gain a better understanding of the disease
  - Gain Nurse Prescribing qualification
  - Network and develop links across partner organisations and their staff to enhance the knowledge of the service and identify areas of on-going support for patients in other services and organisations
  - Developing relationships with GP Practices and the Consultant Neurologists
  - Deliver training to nurses and relevant staff within partner organisations
- Audit of consultant and practice lists to identify SCCCG and VRCCG patients in liaison with GP Practices and the patients' Consultant Neurologists
- Develop a Multi-Disciplinary Team (MDT) approach to the handover of patients on the Consultants' lists to the PDSN
- Support the development of the referral criteria from UHNM Consultant Neurologists to the service for those patient with a confirmed diagnosis of Parkinson's Disease or Parkinsonian related condition (it will not include those ion the early stages of the condition or those that are able to self-care)
- Support the development of the referral criteria from Consultant Neurologists outside UHNM to the service for those patient with a confirmed diagnosis of Parkinson's Disease or Parkinsonian related condition (it will not include those ion the early stages of the condition or those that are able to self-care)
- Develop onward referral pathways to partners to support the care of people with Parkinson's
- Develop PDSN consultation clinics that identify appropriate time slots to enable the management of patient lists – Parkinson's UK suggest that one PDSN can support up to c250 patients
- Work with the main provider UHNM and commissioners, to develop reporting processes to support the delivery and development of the community service.

Stage 3: Service Delivery

The PDSN and Steering Group will lead in the delivery of the service in year 2

- Commence delivery of the service to current patients
- Demonstrate the ramping up of the implementation during year 2
- Accept new referrals from consultants

- Collation of activity and outcome based data to support the preparation of monthly performance and quality report from the provider (UHNM) to commissioners.
- Regular review of the specification to ensure that it is a robust representation of the service

The PDSN will ensure that the patient, their family and carers are aware of:

- How the PDSN community service can support them, as patients with Parkinson's disease or Parkinsonian related conditions and family/carers.
- How to contact the service (by phone in office hours – max 3 working day response)
- How Parkinson disease and Parkinsonian related conditions progresses over the years.
- Possible implications for the patient's life at home and work.
- The impact on other family members' and carers.
- Information, support and sign posting to patients how to contact support groups both locally and nationally. E.g. Parkinson's UK for alternative advice.

For patients accepted on the list for this service the PDSN will ensure:

- that medication is reviewed (and may be titrated) in line with the individual's care management plan provided by the Consultant Neurologist during patient handover
- any issues identified are raised with the Consultant Neurologist.

The service will utilise existing expertise and a multi-disciplinary team approach to improve quality of care for Parkinson's patients

The Steering Group will monitor and performance manage the service in year 2

3.3 Population covered

Once fully implemented the service will be available to patients registered with a GP Practice in SCCCG and VRCCG boundaries with a diagnosis of Parkinson's disease or Parkinsonian related condition, over the age of 18 who will benefit from community based interventions and support (c250 patients). The patients may appear on the Consultant Neurologist list of any Hospital Trust.

Criteria:

- Patients to have a confirmed diagnosis of Parkinson's disease or Parkinsonian related conditions, given by a Consultant Neurologist via referral/letter communication.
- Patients with advanced Parkinson's disease conditions and whose medication regime is not providing satisfactory control.

3.4 Any acceptance and exclusion criteria

Acceptance Criteria

The service will accept patients registered with a GP Practice within the boundaries of SCCCG and VRCCG who have a confirmed diagnosis of Parkinson's disease or Parkinsonian related condition referred from a Consultant Neurologist to the community service via completion of a referral letter and robust care plan (inc medication).

Patients will remain on the caseload of the PDSN while care in the community is appropriate and if required, be referred back to a Consultant Neurologist for a 12 month review in line with NICE Guidelines.

Exclusion Criteria

The service will **exclude** patients who are **not** registered with a GP Practice within the boundaries of SCCCG and VRCCG, or are under 18 years of age. Patients without a confirmed diagnosis of Parkinson's disease or Parkinsonian related condition from a Consultant Neurologist.

Domiciliary Visit Criteria

There may be cases where the community service can provide home visits to patients who are house bound, reside in a care home or receive palliative care. The care of patients in these circumstances will predominantly be delivered by the carers, nurses and community nurses; however there may be circumstance where the expertise of

the PDSN will provide additional benefit, in these cases the consultant should include detail of the requirements on the care plan on hand-over to the PDSN.

3.5 Interdependence with other services/providers

The service will **interface** at an operational level with all services that will support care to Parkinson's patients, this will include, but is not restricted to:

- Community mental health team for older people
- Care of the elderly physicians
- Adult social care
- Primary care
- Community nursing services
- Department of Neurology at University Hospital of North Midlands and other acute trusts where a patient from SCCCG and VRCCG is listed
- Medicines management
- Rehabilitation teams (neuro-outreach, falls, hospital and community teams)
- Intermediate care services
- Independent sector provision (eg: nursing homes, residential homes and care providers)
- Voluntary sector and local branch of Parkinson Society UK
- Parkinson Society UK for completion of service evaluation

The service is **interdependent** with:

- Parkinson UK
- Progressive Supranuclear Palsy Association
- Multi System Atrophy Association
- UHNM Consultant Neurologists
- Consultant Neurologists in other trusts

The service is illustrated in Appendix 4 and has been developed with service user consultation from the local branch of Parkinson UK.

4. Applicable Service Standards

4.1 Applicable national standards (e.g.: NICE)

The service will be delivered in line with the NICE National Clinical Guideline (June 2006) ensuring delivery of the following standards. The new NICE guidelines are in the process of being approved and currently not available but will be applied below once in place.

The standards will form part of the performance report and will be monitored by the steering group

- The aim is for patients with suspected Parkinson's conditions to be reviewed by the Community PDSN service within 6 weeks of referral, achieving 95% as indicated in the NICE Guidelines. The level of service provided through this service specification needs to align with the current standards provided by Hospital Trusts.

- Initially patients in later condition with more complex problems referred from a Consultant Neurologist will be reviewed by the PDSN within 3 weeks with a 5 week follow up appointment with the aim to reduce this to 2 weeks once the service is established, with service achieving 95% as indicated in the NICE Guidelines. Improvements to this target will be agreed through the steering group.

- Patients on the list of the PDSN will be reviewed at regular intervals of 6 months in line with NICE guidance

- Patients will continue with the 12 monthly review with a Consultant Neurologist as per NICE Guidelines, this will be managed by the Neurology department and tot the Community PDSN Service

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg: Royal College)

The service will ensure that an effective, holistic and patient centred approach within a care planning and integrated care co-ordination environment is delivered in line with the National Service Framework for Long Term Neurological Conditions (2005). It will be focused around patient participation in their continued development of their own individualised care plans as identified in the "no decision about me without me" 2012 Liberating the NHS

publication.

Therefore:

- 100% of patients referred to the Community PDSN Service will have a 'Person Centre Care Plan', that is supported by patients notes and reviewed regularly by the PDSN. The process for managing this will be agreed by the steering group

4.3 Applicable Local Standards

The decision on what local KPIs and standards will be agreed by the steering group, they will be measured, monitored and performance managed by the steering group, it will include, but is not restricted to, the following areas:

- deliver 5 training sessions per annum to other health care and social care professionals and non-qualified staff to improve their understanding and management of the condition.
- provide specialist advice and support to other professionals working with an individual patient about specific symptoms or issues, to deliver improved quality of life for patients taking medications.
- regularly gain patient feedback
- To ensure best use of resources the service will ensure all patients of cancelled clinics are provided with no less than 2 weeks' notice, unless in exceptional circumstances. There is no cross cover provided for this service and operate the equivalent of 39 weeks per year.

5. Applicable Quality Requirements and CQUIN Goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Not applicable to year 1 - To be agreed by the steering group and added to Schedule 4 Parts A – D on review of this specification in May 2017

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

None in year 1

6. Location of Provider Premises

The Provider's Premises

Located at:

The service will be provided in a range of settings according to the professional decision and the needs of the patients. The service will provide an in reach service to wards at Mid Cheshire Leighton Hospital, GP Practice clinics, domiciliary care and, when required, by patients residing in care homes, in line with the defined criteria to ensure quality and accessibility of care.

Service Days/Hours of Operation

The service will operate for the equivalent of 39 weeks, Monday to Friday between the hours of 08.00 am 16.00 excluding Bank Holidays, taking into account the PDSN's annual leave and study leave entitlement whilst also accommodating 5 training sessions per year. As with the services set up by PUYK elsewhere there is no cross cover built into the service.

In order to make this an effective community based service clinics will, in the main, be delivered from GP practices and agreed with the GP practices as required. Ashfields Primary Care Centre is identified as the first location. Roll out to other practices will be an on-going development managed by the steering group

The steering group will agree how the service time will be split between delivering clinics in GP Practices, facilitating telephone clinics with patients, undertaking domiciliary visits in the patient's own homes where patients reside in care. The PDSN will be required to allocate time and resources to delivering training, undertaking administrative duties including the production of patient letter and performance reports.

Service Capacity

The steering group will agree the service model, demand and capacity, the following will need to be taken into account:

Most patients reviewed at UHNM are in the South, however patients in Vale Royal are more likely to be on the lists at trusts in West Cheshire, Liverpool and Warrington (plus a few in Manchester) – a proportions of patients will be able to self-care and manage their condition, so not all will be appropriate or suitable for the community service
Past experience of 3 clinics every week with 4 clinics twice per month worked well, suggest similar
This allows for Home visits, MDT meetings, admin, referrals etc, and innovation and developing a service as opposed to just routine clinic appts with no time to build in other areas to the service

Drop in sessions with MDT and joint clinics with MDT.
promoting positive self-management, increased support (pt satisfaction) and reducing unplanned hospital admissions

Current UHNM caseload – Total: 404

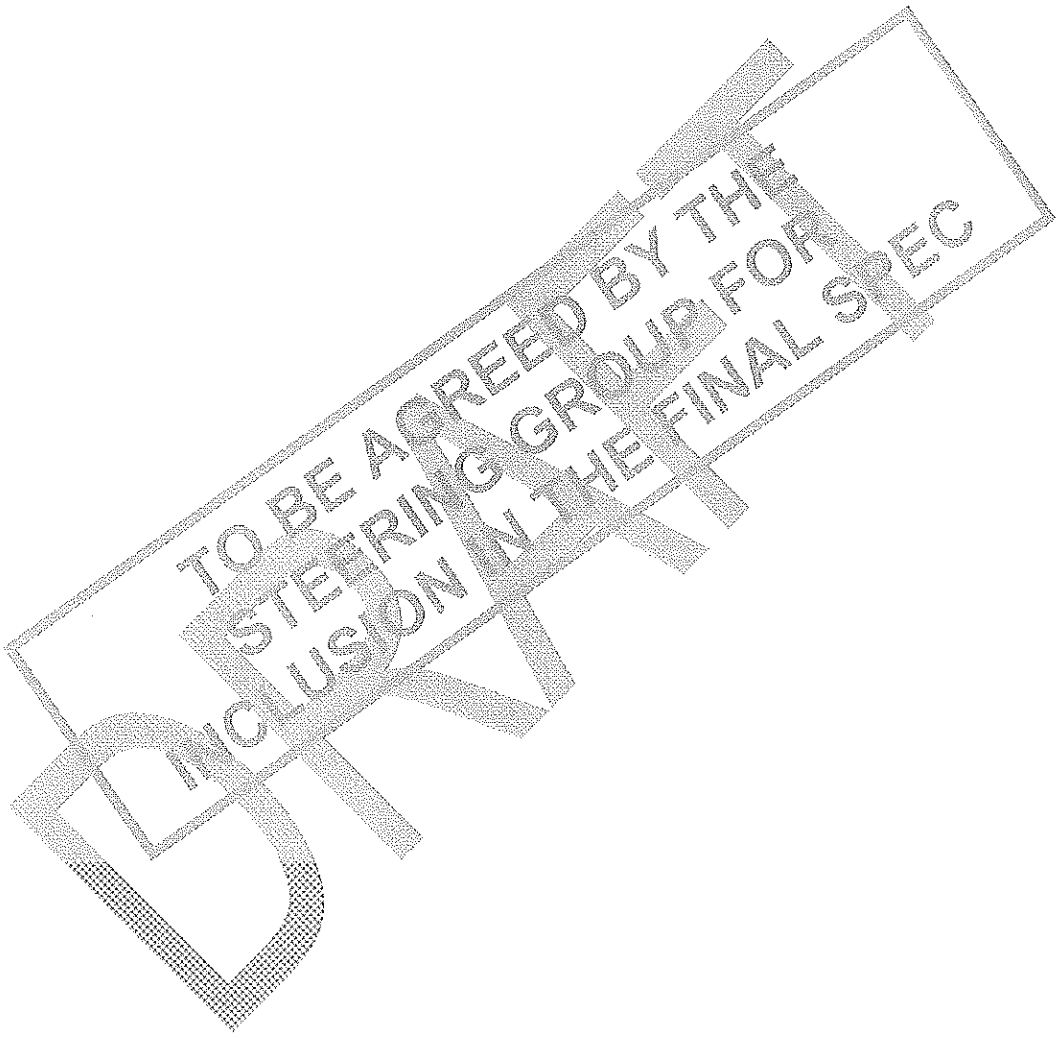
SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

Ref	Operational Standards	Threshold	Method of Measurement	Consequence of breach	Monthly or annual application of consequence	Applicable Service Category

The Provider should be able to demonstrate that they are on track to meet the above indicators at each monthly steering group meeting. There will be an annual review against agreed threshold performance indicators.

Appendix 1: Insert Treatment Algorithm for Parkinson's Disease



Appendix 2: Weekly timetable - to be populated

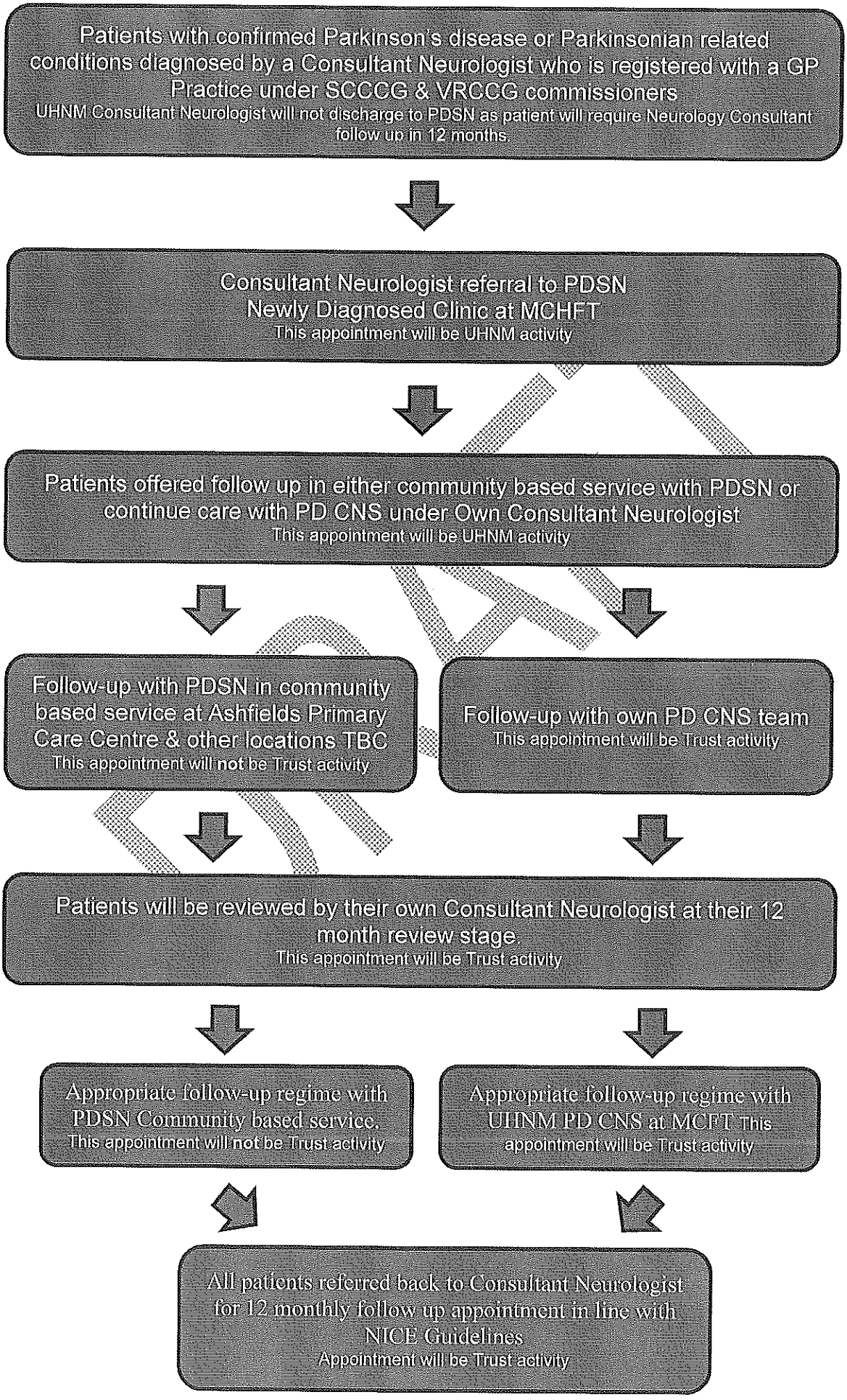
PARKINSON NURSE SERVICE
LOCATION OF SERVICE and CLINICS

Session	MON	TUES	WED	THUR	FRI
AM	?	MCHFT Newly Diagnosed Clinic 5/6 patients	Home Visits	Ashfields Community Follow up Clinic 5/6 patients	?
	Lunch	Lunch	Lunch	Lunch	Lunch
PM	Continuous personal Development	Admin and Telephone Clinic/Ward Visits MCHFT	Networking/PDUK & CCG Meetings	Admin and Telephone Clinic	? MDT Interaction?

Slots required:
1 x MDT interaction (UHNM)
1 x Community Clinics (Further 2 Locations TBC)
3 x Admin/Telephone Clinics/Networking/PDUK & CCG Meetings (MCHFT/various)
1 x Home visits
1 x Ward Visit (MCHFT)
1 x Continuous Personal Development (various)

Appendix 3: Embed Parkinson Nurse Referral form

Appendix 4: Parkinson Nurse Service Care Pathway (Draft)



Appendix 5: embed PDUK/locally agreed patient survey

Appendix 6 NICE Guidance

Please follow the link below, or enter this pathway into your web browser

https://www.nice.org.uk/guidance/CG35