Committee: **Healthier Communities and Older People Overview and Scrutiny Panel**
Date: 19 April 2012
Agenda item: **10**
Wards:
Subject: Implementation of the quality of care in nursing homes review recommendations
Lead officer:
Lead member:
Forward Plan reference number:
Contact officer:

Recommendations:

A. The Committee is asked to note the PCT response to recommendations of the Panel review on Quality of Care in Nursing Homes in 2009

B.

1.1 Purpose of report and executive summary

1.1.1 To provide an update on progress to date, being undertaken and planned against recommendations made in the Merton OSC report

1.2 Details

1.2.1

Sutton and Merton PCT Response to the Report and Recommendations Arising from the Scrutiny Review of the Quality of Care in Nursing Homes in Merton.

For Merton OSC April 2012

Background

The Report and recommendations arising from the scrutiny review of the quality of care in nursing homes in Merton was completed in June 2009. A number of pieces of work have taken place since then which address these recommendations.

Changes in the political landscape of the NHS have led to changes in the NHS which are ongoing. A key change is the planned abolition of PCTs in April 2013, with commissioning responsibility transferring to the Local Authorities, the National Commissioning Board and to GPs as Clinical

Commissioning Groups (CCGs). From April 2013 Sutton and Merton PCT will no longer exist but part of the function of PCT will be replaced by Sutton CCG and Merton CCG. A transitional process commenced in October 2010, whereby corporate functions started being removed from the 5 south west London PCTs (Kingston, Richmond & Twickenham, Wandsworth, Sutton & Merton and Croydon PCTs) and put into a south west London "cluster" arrangement (SWL cluster).

This paper seeks to summarise key developments which have taken place since the report was published as well as outlining projects which are in place or planned which address the recommendations.
Since the report was published there has been considerable change in the structure and priorities of the PCT which remains ongoing. The structural changes of the organisation have already been outlined and other changes will be discussed following. Various pieces of work and projects have been undertaken are ongoing, or are planned which address the recommendations made.
Projects are defined in detail and then comments are made beside each of the recommendations.
It is important to note that while developments have taken place, there is still considerable gain to be made and is important that the new commissioners of the future, i.e. the councils, the CCGs and the National Commissioning Board maintain the momentum on this work.

Actions taken addressing Recommendations

1) Arrangements for Commissioning of Continuing Care

Within SMPCT there has been a PCT specific continuing care team, as has been the arrangement in each PCT. The remit of this team has been to assess individual patient need against continuing care criteria and to organise suitable placement. Aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. Concerns are then raised with the home managers

and if significant it will be investigated as a safeguarding issue and reported to the CQC. If there are issues of significant concern and it is in the person's best interest they may recommend the patient is moved to another home. Historically continuing care placements have been made on a spot purchase basis i.e. individual beds have been purchased from homes on an individual basis. While this has enabled versatility in securing placements in different homes, there have been limited contractual levers to monitor and drive up performance standards. In the last 12 months the team has undertaken 2 procurements for block bed contracts: one for physically frail patients; and one for patients with an organic mental health diagnosis. Within a block bed contract Key Performance Indicators (KPIs) are agreed as part of the contractual process. These KPIs include issues raised in the recommendations, and are detailed in the recommendations section and in Appendix 1. This provides the Continuing Care Team with contractual levers to drive up the performance and quality of care in the Nursing Homes.

This team has always been under considerable pressure due to the high patient demand and limited staffing resource. The PCT is currently working with other PCTS across SW London to review the current model of continuing care teams to build in capacity and scope to take on a more formal role in quality monitoring and safeguarding in the future.

2) QUIPP

Nationally the NHS has introduced the Quality, Innovation, Productivity and Performance Schemes (QUIPP) that all NHS organisations must have in place. Sutton and Merton PCT has been in financial turnaround since April 2011. QUIPP plans have been in place, largely focusing on the productivity element of QUIPP, to address the PCT financial deficit.

One QUIPP scheme currently in development for 2012-13 is one which focuses on improving care in the Nursing Homes. This is largely focused on improving quality and innovation of care within the homes with the expectation that this will lead to a better level of health and reduced unnecessary hospital admissions for Nursing Home residents. This will be a multi-agency approach looking at GP input, Community Services input and supporting the Nursing

Homes to effectively manage contracts and services in place. This project is currently in development.

3) Community Services CQUIN

One of the key actions taken in response to the report was the implementation of a pilot project in some of the Nursing Homes. This pilot was made possible by using the Clinical Quality and Innovation (CQUIN) Incentive Scheme Payment Frameworks. CQUIN Incentive Scheme Payment Frameworks were implemented in 2009-2010 as part of the standard national contracts for Health Services, including Community Services. The CQUIN schemes are specific programs of work to drive quality and innovation, with set goals to be achieved. The programs must be agreed by both provider and commissioner. The Provider is paid for achievement of goals.
As part of the 2011-2012 contract for the Sutton and Merton Community Services a CQUIN scheme was developed and agreed to promote health care in a pilot group of Nursing Homes across Sutton and Merton. In these homes the following activities took place:

- enhanced training to staff in the homes on Falls prevention and management, UTI prevention and management, Dehydration prevention and management, pressure ulcer prevention and management, and management of people with COPD.
- Provision of Nutrition screening and management for residents
- Oral Nutrition Support (ONS) review and dietary education was provided to staff and chefs to ensure efficient use of ONS. This included educating chefs on dietary changes that could be made to fortify a residents diet.
- A Community Nurse was allocated to each Nursing Home to act in a “Lead Review” role. The Nurse provided ward rounds to each nursing home once a week to review each of the residents living in the home

The homes included in the pilot in Merton were: Carter House, Eltandia, Fieldway, Link House, Rosemary Lodge and Woodlands

The CQUIN scheme is detailed at Appendix 2.
The CQUIN scheme ran until the end of March. Evaluation is currently taking place to determine the effectiveness of this project and what elements should be continued and developed to link into the QUIPP Nursing Home project for 2012-13.

In totality the implementation of this project did not result in a reduction of admissions to hospital and the results require further detailed interpretation and analysis.

4) Podiatry Services Review

In Sutton and Merton Podiatry Services are provided by Sutton and Merton Community Services. The Podiatry Service was reviewed in 2010 and redesigned in response to 3 key drivers:

1) During 2009 Sutton LINk commissioned research to solicit the views of the older population in Sutton regarding podiatry and foot-care services, and presented a report with recommendations for improvements to the PCT in November 2009. This report had clear recommendations which were discussed and actions agreed at a series of partnership meetings with key stakeholders from both Sutton and Merton.
2) The Health Service had a requirement to make management savings, so managerial changes took place, with a new management structure overseeing the Podiatry Service. The new management structure found that processes were not running effectively and efficiently in the Podiatry Service and identified changes that were put in place.
3) NHS Sutton and Merton had a significant financial deficit and all services commissioned by the PCT were reviewed to ensure value for money of services provided including Podiatry services. As a result of the service changes implemented from the Sutton LINk report and management review, efficiency savings were made in the Podiatry Service.

Additionally the PCT had been aware of concerns raised regarding podiatry and foot-care through feedback from a variety of sources, and the changes implemented were also to improve the patient experience of the Podiatry Service.
A summary of the changes is included in Appendix 3.
One of the changes includes the provision of training which Nursing Home staff can access. This training provides skills for staff in basic footcare and nail cutting for those who do not meet the NHS eligibility criteria, and also highlights when patients have a clinical need and eligibility for NHS podiatry. Eligibility criteria for NHS podiatry is included in Appendix 4.

5) End of Life Care Strategy

Sutton and Merton PCT first published an End of Life Care (EOLC) strategy in 2007 which was updated in 2011, **(circulated separately to members)**.

A key principle underpinning the strategy has been the implementation of joined up processed in managing EOLC such as the Gold Standards Framework and Co-ordinate my Care. These systems address issues such as:

- *Identifying people approaching the end of life* – equipping staff to be able to do this by providing communications skills training programmes and competency based training.

- *Care planning* – ensuring all people approaching the end of life have their needs assessed and their preferences discussed and recorded. Care plans should be reviewed by multi-disciplinary teams, patients and carers and should be available to all who have legitimate reason to access them (e.g. out of hours services) and should reflect the personal circumstances, including faith and beliefs, of the individual.
- *Delivery of high quality services in all locations* by adopting a care pathway approach and reviewing the availability and quality of end of life care in different settings including hospitals, in the community, in care homes, sheltered and extra care housing, hospices and ambulance services.

With the implementation of the strategy, a program was funded to provide training to Nursing Homes on these systems. In 2011 70% of Nursing Homes in Sutton and Merton had received this training and this program remains ongoing.

6) GP Contract Review

The majority of GPs in Sutton and Merton have been contracted to provide services under a "Personal Medical Services" contract (PMS contract) This contracting arrangement has been under review for the last 2 years, initially within SMPCT and now across the SWL cluster. The review of the PMS contract will ensure that registered patients in Nursing Homes with local GP practices have a consistent payment amount. Currently a review on services that are commissioned for Nursing Homes is underway to align performance and mitigate against duplication of payments as well as trying to improve the quality of care in Nursing Homes, as discussed under 2) QUIPP.

Recommendation	Response and Actions
RECOMMENDATION 1: That L B Merton, CQC and the PCT agree to collaboratively review nursing homes' staff ratios when there are strong odours, to ensure there are adequate staff to meet residents' personal care needs.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.
RECOMMENDATION 3: That the PCT agrees to review the chiropody service, including the waiting list in Merton and the response time, to enable residents in nursing homes to	A Podiatry review was conducted in 2010 and changes made to the service, see point 4) Podiatry Services Review.

access the free chiropody service to which they are entitled.	
RECOMMENDATION 4: That all agencies agree to review the nutritional content of a random sample of nursing home menus and make recommendations if necessary.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care. As part of the Nursing Home CQUIN dieticians worked with the chefs/cooks in the Nursing homes providing training on increasing the nutritional value of meals. See point 3) Community CQUIN.
RECOMMENDATION 5: That nursing homes give regard to residents' daily fluid intake to avoid illnesses such as urinary tract infections and Kidney infections.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.
RECOMMENDATION 7: That L B Merton and nursing homes seek ways to introduce training on person centred planning.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.
RECOMMENDATION 8: That nursing homes work towards providing more person centred activities that meet the needs and preferences of the residents, such as offering various days/times, various group sizes and more one-on-one activities where appropriate.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.
RECOMMENDATION 9: That nursing homes work towards creating more links with the local community, including Merton Volunteer Bureau, to increase support of volunteers.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.
RECOMMENDATION 10: That L B Merton and CQC agree to	These aspects of care are assessed on an individual basis by the continuing care

review the staff ratio of nursing homes, where evidence suggests there is insufficient staffing to adequately meet residents' needs	nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.
RECOMMENDATION 11: That nursing homes aim to provide information and training to staff to increase staff understanding and awareness of various faiths and end of life care.	Through the PCT EOLC strategy training and systems have been provided to Nursing Homes to address these issues. See point 5) End of Life Care Strategy.
Recommendation 12: That representations be made to the Department of Health/NHS London seeking to review the payment to GPs for registered patients in care homes, in addition to the private payment for services to care homes, as part of the GP contract, in order to achieve a standardised fee for the same service.	This is currently being addressed through the PMS review, see point 6) GP Contract Review.
Recommendation 18: That the PCT considers funding for piloting a quality review nurse.	The Community CQUIN pilot, see point 3, attempted to determine the efficacy of this role. Results are yet to be determined.
Recommendation 19: That the PCT develops guidance for nursing homes to report new placements to the PCT within a specific timeframe to ensure residents are linked to relevant support services in a timely manner.	These aspects of care are assessed on an individual basis by the continuing care nurses as part of the reviews for Continuing Health care and Funded Nursing care. See point 1) Arrangements for Commissioning of Continuing Care.

Conclusion

Since the publication of the Report and recommendations arising from the scrutiny review of the quality of care in nursing homes in Merton work has been undertaken to improve the quality of care for people in Nursing Homes. There is still further scope for improvement and projects are ongoing. There is a risk with the changing commissioning environment that this work will be overshadowed by these changes. It is the recommendation that Merton OSC actively engage with the future commissioners i.e. London Borough of Merton

Public Health, Merton CCG and the National Commissioning Board to ensure support is provided to these projects.

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1.3 **Appendices – the following documents are to be published with this report and form part of the report**

Appendix 1
Key Performance Indicators for block contract Care Home Beds

Ref No	Performance Indicator	Information Required		
1	Change in CQC rating	Changed from and to and reason for change	Change/No Change	Explanation of any change
2	CQC reportable incidents	Description and copy of statutory notification	Yes/No reportable incidents	
3	Number of bed days utilised during the period	Number of NHS funded and non-NHS funded bed days utilised during the period	Have you completed and attached the bed occupancy template?	What is the overall % bed occupancy for the home at the end of the month
4	Pre-placement assessments	For NHS funded Service Users: whether or not the anonymised Service User's pre-placement assessment was completed within 48 hours of NHS Sutton and Merton's request	Yes/No	If no, please give details
5	Care Needs Plan reviews	For NHS funded Service Users: whether or not the anonymised Service User's Care Need Plan was reviewed that month	Yes/No	If no, please give details
6	Advanced Care planning	For NHS funded Palliative Service Users: Whether or not the anonymised Service User's Advanced Care Plan was completed within 1 week of admission	Yes/No	If no, please give details
6a	Advanced Care planning	For NHS funded non-palliative Service Users: Whether or not the anonymised Service	Yes/No	If no, please give details

		User's Advanced Care Plan was completed within 1 month of admission		
7	Number of FTEs	Number by registered nurses and care assistants	Please state number and WTE of registered nurses and health care assistants	
8	Permanent staff	As a percentage of FTE, by registered nurse and care assistant		
9	Bank / agency	As a percentage of FTE, by registered nurse and care assistant		
10	Short term vacant posts (have been vacant for 3 months or less)	As a percentage of FTE, by registered nurse and care assistant		
11	Long term vacant posts (have been vacant for more than 3 months)	As a percentage of FTE, by registered nurse and care assistant		
12	Staff Sickness	As a percentage of FTE, by (1) registered nurse, (2) care assistant, (3) catering, cleaning, laundry, (4) Management and (5) Admin/reception staff		
13	Staff training undertaken	Number of staff and type of training provided, by registered nurse and care assistant		
14	Staffing	• Suspension / disciplinary action taken against staff • Turnover		
15	Feedback on quarterly Service User / their representatives forum	Minutes from meeting		
16	Complaints monitoring	Resolved complaints: outcome of complaint and action to mitigate reoccurrence Unresolved complaints: action plan to deal with complaint and timeframes for completion		

17	Compliments monitoring	Type and detail of compliment	Compliments received Yes/No	If yes, please give detail
	Sections 18 to 24a refer to ALL patients in the home			
18	Falls[1]	For NHS funded Service Users: by anonymised Service User, description of each fall For non-NHS Service Users: description of each fall	Please state number of falls, if any	If any, please give details
19	Unplanned hospital admissions	For NHS funded Service Users: by anonymised Service User, date and reason for admission For non-NHS Service Users: reason for each admission	Please state number of unplanned admissions, if any	If any, please give details
20	Infection issues	For NHS funded Service Users: by anonymised Service User, description of specialist care procedures applied For non-NHS Service Users: description of specialist care procedures applied	Please state number of infection issues, if any	If any, please give details
21	Medication issues	For NHS funded Service Users: by anonymised Service User, description of why GP was urgently contacted re medication issues For non-NHS Service Users: description of why GP was urgently contacted re medication issues	Please state number of medication issues, if any	If any, please give details
22	Pressure sores	**Post placement** For NHS funded Service Users: by anonymised Service User, grade of pressure sore (4,3 or 2), description and confirmation that treatment plans are in place	Please state number of post placement pressure sores, if any	If any, please give details
23	Pressure sores	**Pre placement** For NHS funded Service Users: by anonymised Service User, grade of	Please state number of pre placement sores, if any	If any, please give details

[1] An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness (NICE 2004)

		pressure sore (4,3 or 2), description and confirmation that treatment plans are in place		
24	Leg ulcers	**Post placement** For NHS funded Service Users: by anonymised Service User, description of leg ulcer and confirmation that treatment plans are in place	Please state number of post placement leg ulcers, if any	If any, please give detail
24a	Leg ulcers	**Pre placement** For NHS funded Service Users: by anonymised Service User, description of leg ulcer and confirmation that treatment plans are in place	Please state number of pre placement leg ulcers, if any	If any, please give detail
25	Service Users prescribed Liverpool Care Pathway	For NHS funded Service Users: description of care prescribed		
26	1 to 1 Enhanced Observation	Provide written evidence of patient requirements for all incidents of 1 to 1 Enhanced Observation by Registered Nurse or Care Assistant		
27	Demanding Patient Behaviour	Provide written evidence of all incidents of demanding patient behaviour and measure taken to manage this behaviour		

Completed quarterly information submissions must be returned no later than 5 working days after the end of quarter.

Appendix 2
Extract from contract 2011-2012 Community Contract

SECTION 4 – INCENTIVE SCHEMES

Section 4.1 – Commissioning for Quality and Innovation (CQUIN) Incentive Scheme Payment Framework

Goals and Indicators

4	**To reduce the number of emergency hospital admissions from 10 Nursing Homes identified by the commissioners (30%)**	Effectiveness and Experience	i)	Tailoring, designing and implementing training packages for each Nursing Home to reduce hospital admissions	local	10%
			ii)	To provide Nutrition screening and management for 95% Nursing home residents	local	5%
			iii)	To undertake ONS review and dietary education for staff and chefs to ensure efficient use of ONS	local	5%
			iv)	To provide ward rounds to each nursing home once a week.	local	5%
			v)	To demonstrate a reduction in admissions from the nursing homes	local	5%

4) Detail of Indicator (Reduction in Admissions from Nursing Homes (30%)

Description of indicator	To reduce the number of emergency hospital admissions from 10 Nursing Homes identified by the commissioners by: i) Tailoring, designing and implementing training packages for each Nursing Home to reduce hospital admissions (to include Falls prevention and management, UTI prevention and management, Dehydration prevention and

	management, pressure ulcer prevention and management, management of people with COPD and other identified high level reasons for admission) ii) To provide Nutrition screening and management for a) 95%of Nursing home residents within the first quarter and b) 95% of new residents within 30 days of admission iii) To undertake ONS review and dietary education for staff and chefs to ensure efficient use of ONS iv) To provide ward rounds to each nursing home once a week. v) To demonstrate a reduction in admissions from the nursing homes
Numerator	i) N/A ii) a) Number of existing NH residents (at an agreed census date) who receive nutrition screening b) number of new NH residents following the census date to receive nutrition screening iii) N/A iv) Number of ward rounds provided (split by nursing home) v) N/A
Denominator	i) N/A ii) a) Number of existing NH residents (at an agreed date) b) number of new NH residents following the agreed date to receive nutrition screening iii) N/A iv) Number of ward rounds expected during the reporting period v) N/A
Rationale for inclusion	This CQUIN aims to improve the healthcare and quality of life for Nursing Home residents and thereby reduce the number of unplanned hospital admissions. This aims to improve health and reduce acute expenditure.
Data source and frequency of collection	RMH – i), iii), v) quarterly and ii) and iv) monthly
Organisation responsible for data collection	RMH

Frequency of reporting to commissioner	RMH – i), iii), v) quarterly and ii) and iv) monthly
Baseline period / date	N/A i – iv V – Q4 10/11
Baseline value	Commissioners to confirm in Quarter 1 for identified Nursing Homes
Final indicator period / date (on which payment is based)	Payment each quarter against targets
Final indicator value (payment threshold)	As per targets above or goals below
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Full achievement of targets or agreed milestones for full payment for all goals. For ii) and iv) must achieve within 10% of target to receive 50% of payment
Final indicator reporting date	Month 11 2012 ie 15th working day of March 2012
Are there rules for any agreed in-year milestones that result in payment?	i) Q1 training needs analysis, training program and implementation plan agreed with commissioners, nursing homes and key stakeholders commissioners for Q2 , Q3 and full implementation by Q3. Q2 and Q3 achievement of targets on implementation plan Q4 report demonstrating training implemented and further recommendations.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Full achievement of targets or agreed milestones for full payment for all goals. For ii) and iv) must achieve within 10% of target to receive 50% of payment
Rules for any agreed in-year milestones that result in payment including evidence to be supplied	As above
Rules for partial achievement against final indicator period/date and/or in-year milestones	As above

Appendix 3
Podiatry Review Action Plan 2010

Issue and Background	Actions/Plans
Provision of foot-care services The NHS is committed to providing health care. Historically there has been overlap between the provision of podiatry to meet health needs and the provision of foot-care. In keeping with current practice, the PCT now commissions podiatry services only. This issue was raised in the Sutton LINk report and 3 options were proposed and have been responded to as noted.	Option 1: Foot-care service directly commissioned by NHS – the majority of PCTs do not commission foot-care as it is not a direct health service and it is not feasible to fund this within current financial resources. Option 2: Partnership Foot-care Service between NHS with the Voluntary Sector – this option is being taken forward. In Merton Age Concern use the podiatry clinics for 2 sessions per week for Foot-care. This option has also been offered to Age Care Sutton and a meeting is planned with Marion Harper and NHS staff to discuss this offer. The Podiatry service are running free Foot-care training sessions to voluntary sector organisations, Day Centres and Nursing and Residential Homes to up skill organisations in the community to be able to provide Foot-Care services. Two foot-care training sessions are planned for October and November 2010. This is planned to become a rolling programme. The training gives non-NHS volunteers and staff the skills to be able to carry out foot-care procedures and the knowledge to be able to determine when the condition of the foot is greater than foot-care and a podiatry referral is required. Option 3: Partnership Foot-care Voucher Scheme – Local Authority staff determined that this was not a feasible option to proceed with.
Poor access to clinical care Historically there have been complaints of long waits for podiatry and concerns over availability of service. The service had a high level of inappropriate referrals leading to wasted administrative and clinician time to review and redirect these	It is proposed to make the following changes to improve the efficiency of the service: 1: **Referral pathways** – 40% of all referrals were found to be inappropriate and of these 80% were self-referrals. Processing and assessment of inappropriate referrals was blocking administrative time as well as podiatrist

referrals. A high proportion of the inappropriate referrals were self – referrals indicating that it is difficult for the general public to make clinical decisions on podiatry	time as all referrals were clinically triaged. Eliminating these inappropriate referrals is predicted to increase capacity by 15 new patient appointments per week. To reduce the number of inappropriate referrals, the referral pathway has been redesigned so that all new referrals will be made by a GP, Healthcare professional, social care professional or a voluntary staff member who has received referral training. Existing patients meeting the podiatry criteria will not require re-referral. **2: Clinic Locations** - The podiatry clinics are currently spread across 11 sites which run on full time or part time basis. It is proposed to reduce the number of sites to 4, with these being Wideway, Patrick Doody, Shotfield and Priory. This will enable efficiencies to be achieved in decontamination costs, administrative and clerical processes and reductions in travel time between clinics and for domiciliary visits. It also provides greater clinical flexibility during annual leave and sickness. Those patients currently eligible for transport will continue to be able to access this. By improving the overall efficiency of the service there will be a greater capacity for improved patient care.
Poor administrative processes	On the recommendations of this report, the service provider has reviewed the referrals and appointment system. Actions taken and planned are: **Appointment Process** –the service has moved onto the "RIO" electronic record system. All patients who need a follow up appointment are booked in at the time of leaving the clinic and given an appointment card. The service is piloting phone reminders for 1 clinic. **New referral pathways** – proposed to go live from 1st December following communications and engagement. **Reduced Clinic Locations** – this will also create more capacity for administration staff to be able to

	respond to patients and to provide cross cover.
Poor communication of Podiatry Services	A communications sub-group for the podiatry service redesign has developed a plan to communicate service changes which will be implemented over October and November. The group will also oversee the development of a patient leaflet. A copy of the communications plan is attached

Appendix 4

Podiatry Services Criteria – Extract from 2012-13 Contract Podiatry Service Specification

Referral criteria and sources

- Patients must be registered with a Sutton and Merton GP; or be patients for whom the commissioning body is responsible for under the Responsible Commissioner Guidance.
- Patients who require a home visit must be referred by a GP or health care professional and must meet the housebound criteria.
- For Home Visits, the patients home and social situation must be conducive to treatment. If the home or social situation presents a risk to either the therapist or patient for treatment, alternative arrangements will be made to see the patient
- Patients must be able to consent to treatment in accordance with legal and profession Consent to treatment standards.
- Patients must have a condition of the foot or lower limb suitable for podiatry as per examples below:

    - Lower limb and foot dysfunction, which may result in painful leg and foot symptoms, for example a sporting injury.
    - Dermatological (skin) conditions including corns, callus and persistent or painful verrucae.
    - Foot and toe deformities e.g. bunions
    - Painful in-growing toenails
    - 'High risk' feet, linked to complications such as poor circulation, nerve damage, or people with compromised immune systems.
    - Wound care, including foot ulceration (excluding patients with diabetes, who should be referred immediately to hospital based Diabetes specialist services).
    - Foot health education, e.g. advice on nail care and footwear.
    - Minor surgery e.g. nail surgery.
    - Topical chemical therapy.
    - Biomechanics – provision of insoles or orthotics to control foot position.
    - Biomechanics – lower limb pain.
    - Patients with diabetes, peripheral neuropathy or a significant long term condition leading to impaired sensation and functional ability and who are unable to self-care and are at risk of damage to their feet may be eligible for support with foot care.

Referrals may be made by Health Care Professionals, GPs, Social Care staff or other voluntary sector organisation, nursing or residential care staff who have received training in foot care and podiatry referrals.

Housebound Patients: These are patients who are able to mobilise around their immediate environment, albeit with difficulty, but are unable to mobilise to any significant degree outside of the home environment. People so described would be able to get themselves up and dress (again perhaps with difficulty) but would not be able to undertake any external tasks (shopping, attending appointments etc) without assistance from other people. This assistance may vary from a vehicle and a "helping hand" (usually covering assistance with stability and balance but not significant lifting carrying or manual-handling input) through to the use of manual handling equipment and specialist mobility aids to manoeuvre the user into a safe travelling position.)