Local Commissioning

Nottingham University Hospitals NHS Trust Service Reviews

1. Introduction

CCGs have a duty to act efficiently, effectively and economically and in order to do this, we are continually reviewing and planning services to meet the needs of the local population and to secure value for money. The Nottingham University Hospitals NHS Trust (NUH) service reviews are an element of this.

With agreement from NUH, over the last year, a team of clinical staff have been reviewing some of the services provided at the QMC and City Hospitals, to ascertain whether they are being provided in a more appropriate setting and whether they are delivering best value for money. As part of these reviews, the CCG governance processes have been followed, including the completion of quality impact assessments (QIA) and equality impact assessments (EIA) and patient and public engagement. These processes have been iterative and are continuing in both County and City in order to inform decisions.

As part of the process, consideration has also been taken with respect to future planning and the aims of the STP. As a result, NHS Nottingham City CCG are managing the proposals from the service reviews along with plans to commission a multispecialty community provider (MCP).

A list of the services being reviewed is provided in appendix one of this document, including the proposals. Overall the services are ones that are not bed based and are not part of essential/core care in a hospital environment. As such, the reviews considered whether services could be more appropriately provided differently and/or in a community setting.

CCGs want to reassure people that the reviews have been about looking at ways in which services can be delivered more effectively and efficiently. Services are not stopping. The driver of the review has been improving quality under an environment of increasing cost pressures.

In Nottingham and Nottinghamshire we are fortunate to have highly competent, skilled and clinically robust services across primary (including GP practices), community and hospital (acute) care. Our aim through the reviews is to commission services that capitalise on utilising the full range of the high quality service provision available to us. It is important to acknowledge that if services are moved to the community we will continue to maintain the specialist elements of clinical care that are required. If we decide to move a service, it will be to ensure that patients are receiving the right care in the right place. This helps to support the CCGs deliver their statutory duty to offer the best service possible within the budget that is available. It is important to emphasise that if a patient requires treatment in hospital then they will continue to receive such treatment; services will be delivered in the most appropriate setting clinically.

Therefore, the majority of reviews have resulted in a proposal that services remain at NUH with an updated specification, the remainder, in proposals that the service be moved to enable them to be provided in a community setting or the patient's own home.

2. Patient and Public Involvement and Clinical Involvement

2.1 Patient and Public Involvement

As outlined above, proposals are around individual services and the approach to engagement has been taken in order to facilitate involvement relative to the type of change, whether it impacted on patient outcomes, the significance of the change taking into consideration the size of the service and/or the number of people affected.

The following are the engagement activities that were carried out by Nottinghamshire CCGs with service users and the public in order to inform the proposed specifications:

- Local surveys
- Focus groups with service users and carers
- Reaching out to local interest groups ie Headway, Fibromyalgia Action Group, MND Association Nottingham
- One to one meetings with service users and carers
- Existing patient and public involvement intelligence
- Where relevant, national surveys and resources were also used to validate the feedback received locally ie commissioning guidance for rehabilitation, Improving MND Care Survey, NICE consultations

At the start of this process it was not possible in all cases to contact service users directly. Therefore, CCGs actively sought to involve service users, carers and potential service users through existing networks and outreaching to the general public.

This work started in August 2016 and is ongoing by Nottingham and Nottinghamshire CCGs, depending on the service line and where it fits with future planning.

In addition to the above, engagement on the proposed specifications has been carried out and is also ongoing. Where the proposal has been to move the service into the community, details of proposed changes have been included on Nottinghamshire CCG web-sites, and available through PALS,for people to comment on. The majority of the proposals were put on web-sites on the 21st December with an end date for comments of the 5th February 2017. Dietetics and Orthoptics are following different timescales. Ongoing engagement also includes focus groups , engagement with local interest groups and individual input. Alongside putting the proposals on the web-sites in order to receive feedback, information has been sent out through networks (to individuals and groups) on the engagement including on the radio and tv. Service users and the public have been invited to comment in writing or by phone, as well as electronically.

2.2 Clinical Involvement

CCGs requested clinical input from NUH in order to inform the specifications and proposals. This was supplemented with additional broader clinical views by:

- Asking all local providers, including NUH, to nominate clinicians who could be involved with the work
- The Clinical Senate circulating their wider membership to ask for people who would be prepared to support the reviews
- Approaching key individuals or organisations relevant for the service e.g. Local Optometrist Committee, Charted Society of Physiotherapy, specialist advisors
- Clinical engagement events were held for some service areas
- Public health provided support in relation to the evidence base and service models for some teams

As with patient and public involvement, clinical engagement has been ongoing, including additional focus groups and one to one meetings.

3. Conclusion and Timescales

Where services are staying with NUH, CCGs are working closely with the relevant clinicians, managers and service users on plans for 2017/18. This may include finalising the specification, performance measures and patient outcomes and progress is dependent on the service line.

For those services that may be going out to procurement, it is expected that this process will start in February and this is to be finalised following the review of engagement feedback. Where required, procurement processes will align with a mobilisation and implementation date in July.

Also, during 2017 Nottingham City CCG are going out to tender for the MCP Contract which will commence on 1st April 2018. Services decommissioned from NUH will be directly awarded to existing community providers on a short term basis to enable the CCG to align timescales and consolidate contracts for maximum efficiency. Legal advice has been taken on this approach and all providers will have the opportunity to bid for the services in the long term and participate in the engagement events for the MCP.

CCGs will develop plans with NUH and the new providers, where relevant, (when known) on exit strategies to ensure that, existing and new patients continue to access services as per their patient journey and appropriate handovers are managed with clinicians.

Appendix 1

* No. of Patients or Contacts - It is not possible to report on activity by number of patients across all services. This is because data collection has not been consistent across services and may also have been impacted by contractual agreements ie block versus activity based contracts. Number of patients or contacts includes all patients that are seen by the service, including patients who may be registered outside of Greater Nottingham CCGs, therefore, actual numbers pertaining to the proposals will be lower.

1. Proposal for Services to Remain at NUH with Updated Specification

A. Change in Service Design

Clinical Psychology	Current Service	The core purpose of this specialised service is the assessment and treatment of psychological distress related to a physical illness. Currently provided in a few specialties.
	No. of Patients or Contacts*	3576 contacts
	Proposal	The service will develop to provide an equitable and targeted specialist service to patients for all specialties where there is a psychological need associated with a physical illness.
Outpatient Physio and Complex Orthopaedic Rehab	Current Service	Outpatient physio (including women's health, support to fracture clinic, burns and plastics, spinal, pain, paediatrics, sports medicine, hands, shoulders, orthopaedics including prehabilitation, and post operative treatments) and orthopaedic rehab service
	No. of Patients or Contacts*	ortho rehab 630/physio 29,525/1386 group sessions
	Proposal	Outpatient physio and orthopaedic rehab service including women's health, fracture clinic, burns and plastics, spinal, paediatrics, sports medicine, hands, shoulders, pre-op, post-op. Pain will be part of new service model. Services to review how can integrate with community rehab services.
Orthotics	Current Service	The Orthotics Department provides an outpatient service for the professional assessment, prescription and provision of orthotic devices, including (but not exclusive to) functional foot orthoses, ankle foot orthoses, knee ankle foot orthosis, orthopaedic footwear, spinal and upper limb orthoses. These are intended to assist the functioning of a deformed or weakened part of the body, improve mobility and reduce pain.
	No. of Patients or Contacts*	11 847
	Proposal	Where patients would be able to purchase a suitable orthoses over the counter the Orthotics Department will recommend the product. Products will stocked by NUH pharmacy. Where products are not available over the counter and patients could have their needs met by the community podiatry service, the Orthotics Department

		within the hospital will recommend this approach, this will be facilitated through the agreement of referral criteria and patient pathways for the two services.
Critical Care Outreach	Current Service	Critical care is usually only offered to those patients presenting with a potentially reversible condition. It is expected that patients who require critical care have access to appropriate care whether in a designated critical bed or via outreach services, as soon as possible, in accordance to their individual needs, and that care in the services continues at the relevant level throughout the patients stay.
	No. of Patients or Contacts	Information not available
	Proposal	Critical care specification has been amended to include critical care outreach as this is included in tariff from 17/18. CCGs are keen that the Trust continue to optimise the team's role in managing the bed base within critical care and eliminating admissions to the unit where their in put enables the base ward team to manage the patient safely and effectively.
Anti-Coagulation Remote Dosing Service (ACORDS)	Current Service	To offer safe anticoagulation management for patients prescribed warfarin (or other vitamin K antagonists VKA). Anticoagulants have a narrow therapeutic margin and are safe only if monitored closely. Anti-coagulants are one of the classes of drugs most commonly associated with fatal medication errors. The anticoagulant remote dosing service is designed to ensure that consistent high standards of clinical care are delivered conveniently and safely to patients on anticoagulation therapy.
	No. of Patients or Contacts*	9000
	Proposal	The proposal being considered is to keep the current service with the introduction of self-monitoring coagulometers (assistive technology) and offering patients informed choice of anti-coagulant agents (DOACs).
Dialysis Home Visits	Current Service	Training and assessment of patients competency to self-manage their dialysis. Includes at least one home visit per month delivered by a registered nurse. Home visits teach, support, guide and review both the health and ability of the patients to cope with their treatment.
	No. of Patients or Contacts*	275
	Proposal	The proposal is to continue with the service delivered by a registered nurse. Review of frequency of visits is being agreed as part of the specification.

B. No Change in Service Design

Outpatient Speech and Language Therapy for ENT patients(SLT)	Current Service	This service delivers a triage voice clinic for the initial assessment after consultant referral from the general Ears Nose and Throat clinic with a request for SLT involvement
	No. of Patients or Contacts*	
	Proposal	To continue to provide the service at NUH with no changes.
Specialist Palliative Care Pre-Assessment	Current Service	To provide a Specialist Palliative Care Day Therapy to allow the assessment and management of the complex palliative care needs of adults living in Nottinghamshire.
	No. of Patients or Contacts	2586
	Proposal	Patients will have their assessment and induction in the specialist palliative day care service as part of their first visit. Current service sees an average of 14 patients per day with a capacity to see 25. Pricing has been reduced to reflect activity.
Community Paediatrics	Current Service	Community paediatrics service being provided without clarity on outcomes and model to deliver statutory requirements.
	No. of Patients or Contacts	Not applicable as relates to delivery of statutory functions.
	Proposal	The service will remain in NUH and the proposal is that it is provided in line with five specifications including statutory responsibilities. Five specifications include designated professional services, looked after children, safeguarding, rapid review of sudden deaths, non-statutory provision.
Outpatient parenteral antimicrobial therapy (OPAT)	Current Service	The OPAT service is designed to reduce the length of stay in acute hospitals for delivery of IV antimicrobial antibiotics and to improve the patient experience by avoiding an unnecessary lengthy hospital stay. The service reduces the length of stay for those infections which are at a stage where they can be safely managed within a community setting. The service treats patients in their home environment for receiving OPAT when meeting the agreed criteria.
	No. of Patients or Contacts*	10601
	Proposal	To continue with the service and specifically target provision to the areas which will be of greatest benefit in helping flow of patients.

Outpatient Occupational Therapy	Current Service	To provide a structured and consistent approach to delivery of occupational therapy through multidisciplinary working, promoting effective working relationships with the clinicians within the acute setting, community services and Primary Care.
	No. of Patients or Contacts*	9161
	Proposal	It is proposed that the service will remain the same with agreed patient outcomes aligning with commissioning intentions.
Dietetics Total Parenteral Nutrition (TPN)	Current Service	The aim of the dietetic support to home TPN service at NUH is to provide a structured and consistent approach to delivery of Home TPN through multidisciplinary working, promoting effective working relationships with the clinicians within the acute setting, community services and Primary Care.
	No. of Patients or Contacts	Caseload is 77 patients per month
	Proposal	There is no change to the service provided. Specification and contract agreed.
Hepatitis	Current Service	The aim of the service is to maximise appropriate uptake and completion of Hepatitis C and Hepatitis B treatment and to cure more people of infection and reduce the risk of onward transmission.
	No. of Patients or Contacts	Information not available
	Proposal	There is no change to the service provided. Specification and contract agreed.
Audiological Medicine	Current Service	To provide Consultant led treatment to patients who have intractable imbalance, dizziness, vertigo and tinnitus issues that in general have failed to have their conditions managed or diagnosed by either ENT or Audiology services
	No. of Patients or Contacts*	828
	Proposal	There is no change to the service. Referral pathway clarified for GPs. Specification and contract agreed.

C. Non patient facing service and/or tariff change

Advice & Guidance	Current Service	Clinician to clinician service providing advice and guidance in relation to specific patients and specialties.
	No. of Patients	Not applicable
	Proposal	All advice and guidance specified within the NHS Standard Contract will continue to be provided.
Healthcare Associated Infection Co-ordination Service & Infection Control Doctor	Current Service	To provide infection, prevention, control and treatment specialism at the interface between secondary/laboratory and community/primary care.
	No. of Patients	Not applicable
	Proposal	To remove duplication across the two services by commissioning a single service.
Pre-operative Assessments	Current Service	To provide pre-operative assessments
	No. of Patients	Not applicable
	Proposal	Pricing will fall under national tariff as opposed to a locally agreed price.

2. Proposal for Service to be all or Partially Community Based

Chronic Fatigue Syndrome	Current Service	The current service at Nottingham University Hospitals (NUH) assesses and helps those patients diagnosed with mild to moderate Chronic Fatigue Syndrome (CFS). The service supports patients to develop appropriate strategies for managing their symptoms and improving their quality of life. Patients begin with a therapist or consultant assessment. Patients can be discharged at this point with advice, or they can receive one or more of the following interventions: • 6-8 individual sessions with an occupational therapist • 9 week group programme led by appropriate therapists • 10 -12 individual Cognitive Behavioural Therapy (CBT) or Psychology sessions
	No. of Patients or Contacts*	Consultant 77/CBT course 158/Group Therapy 449/Individual 251/Assessment 125
	Proposal	The National Institute for Clinical Excellence (NICE) has published guidelines for CFS management which recommend the following: • Patients and therapists working together • Cognitive Behavioural Therapy • Graded Exercise Therapy

		• NICE highlights that these are the interventions for which there is the clearest evidence of benefit. In addition the guidelines advise that CFS services should provide support if symptoms worsen during treatment and should develop a plan to manage relapses. It is proposed that this service provides evidence based interventions only, as identified by NICE. The proposal is that a community based service will provide the following: • Be delivered by a multi-disciplinary team which will include appropriate CFS specialists that can triage all referrals and manage patient's physical, psychological and social needs • Act as a single point of access for patients with chronic pain or CFS providing a simpler patient journey • Provide a holistic assessment and management approach for patients with chronic pain or CFS as early as possible in the pathway • Support patients living with chronic pain or CFS and their nominated carers to: o manage their own condition and make decisions about self-care and treatment o allow them to live as independently as possible continue care and support (where appropriate) learnt through the service post discharge • Provide appropriate access points for patients and carers following discharge to support in the management of flare ups and avoid re-entry into the service where possible As part of the proposal, the group therapy that is currently provided will not continue. It is proposed that this service could be integrated into existing community based physio and rehab services. In order to ensure the specialist skills for CFS continue in the community the specification will include the requirement that clinicians have the competencies required to work with CFS patients.
Back Pain and Pain Management	Current Service	The current pain service is very fragmented with different services being provided in different areas. There is a lack of clarity as to which service is most appropriate to meet patient needs. Within NUH there is a pain management service and a separate back pain service, as well as outpatient appointments for joint injections and consultant clinics.

		The current service specifications provide a multi-disciplinary approach to the management of pain, working within a cognitive behavioural therapy framework. The services incorporate therapy, nursing and psychology input to deliver biopsychosocial assessment and support for people with long term pain.
	No. of Patients or Contacts*	pain mgmt. 483/back pain 2714
	Proposal	In developing this proposal, a review of the evidence of the clinical and cost effectiveness of interventions currently used has been conducted by Public Health colleagues and in conjunction with the Core Standards for Pain Management in the UK (Faculty of Pain Medicine Oct 2015), NICE guidance and SIGN guidance. It is proposed that pain management services should be delivered through a three level system: • Level One - primary care services from GPs, community pharmacists, community psychological therapies, pain self-help organisations/groups and community based physical and psychological therapies. • Level Two - community based services offering a multi-disciplinary team approach to pain management or CFS care including specialist physical and psychological therapies, evidence based interventions such as exercise programmes and access to self-help resources. • Level Three - secondary care service for patients requiring surgery or procedures that require an acute care setting. Referrals to this service must be in line with the agreed service pathway The proposal is that the Level Two service will consist of a multi-disciplinary team that can assess all referrals, and manage patient's physical, psychological and social needs associated with pain. The proposal aims to ensure that patients experiencing chronic pain are appropriately managed in a community environment. Patients requiring secondary care can be referred into an appropriate hospital setting when they need specialist interventions and the proposal is that they will then be transferred back to a community setting (if necessary) once Level Three intervention is complete. It is proposed that the use of a "never discharged but not followed up" policy will be adopted to enable long term follow up of patients at set points as agreed with the patient. This enables the patient to self-refer back into the service directly when agreed changes in their condition are noted or if the patient/carer/family need to seek advice to assist in self-management. It is proposed that

		all patients will have a comprehensive treatment plan which uses standardised language and terminology to enable colleagues across services to talk to the patient regarding their care plan using common language that everyone understands. The treatment plan will include a clear explanation of the circumstances that require them to re-engage with the service, how to manage flare ups and the importance of contacting the service at these times in preference to primary care or attending ED where possible It is proposed that reducing the fragmentation of the current pathway for patients with chronic pain and ensuring more standardisation in the treatment of patients will reduce duplicating or overlapping service provision and consequent extra payment for the same or similar service.
Renal Home Visiting (Renal Conservative Management)	Current Service	End of life support through the Conservative Management Home Visiting Service for end stage renal disease. The current service provides advanced care planning, symptom management, practical nursing care, facilitates end of life care and discusses preferred place of care and death.
	No. of Patients or Contacts*	84
	Proposal	There are currently other dedicated end of life services provided in the community and therefore the proposal is to move this service to the community with the aim of fully integrated care. It is proposed that this could allow for a greater emphasis on patient outcomes and how to meet these and improved patient and carer experience. The proposed change takes into consideration the removal of duplication in services and as a result, could provide better value for money. The proposal outlines a case management approach: Principles include: • 24 hour nursing care within their own home due to long term chronic disease or as a result of an acute episode of ill health; • Ongoing case management or rehabilitation as a result of a long term condition(s) or complex needs from multiple conditions. • Adherence to and provision of evidence of compliance with the NICE quality standard for End of life for adults

		The proposal is that the service will continue to be provided in a patient's own home and the aim of the new model is care co-ordination across other relevant community services.
Moto Neurone Disease (MND) Co-Ordinator	Current Service	The MND Care Co-ordinator provides home visits which include a holistic health, psychosocial and physical review. The main emphasis being on MND symptom management control.
	No. of Patients or Contacts*	27
	Proposal	In reviewing this service the proposal takes into consideration the view that there is duplication with services provided in the community. It is proposed that if the service was moved out of the acute setting this could allow for improved integration of care and as a result a greater emphasis on patient outcomes. It is proposed that care will still be provided in a patient's home as required. The proposal is to maintain the current principles of crisis management, rehabilitation, self-management. The following care is provided under the existing service and it is proposed that it will continue with the new service: • Assessment of oxygen saturation levels • Swallow assessment • Nutrition assessment • Activities of daily living assessment • Discussion regarding Do Not Resuscitate • Discuss advance decision to refuse treatment (and put this in place) • Facilitate end of life care with community teams and GP • Discuss preferred place of care and death The proposal includes care co-ordination across other relevant community services. It is proposed that links with the acute neurology team will remain.
Geriatric/Medicine Day Care	Current Service	The Nottingham University Hospitals Rehabilitation Unit (NUHRU) provides specialised comprehensive, multidisciplinary assessment and individualised treatment programmes to meet the goals and needs of frail older out-patients whose needs are too complex to be provided for effectively in community i.e. complex falls patients, early complex stroke patients, Parkinson's Disease patients and complex geriatric patients. Patients are discussed at a multidisciplinary team (MDT) meeting, and a goal-oriented, individualised care plan produced.

	No. of Patients or Contacts*	Falls 279/Parkinsons 79
	Proposal	The proposal is that the service will be provided in either a community location with specialised equipment or in the home environment. Referral criteria will remain the same, along with a focus on complex falls and complex neurological conditions including Parkinson's Disease. It is proposed to deliver rehabilitation for this cohort of patients with the aim of services being integrated. The aim of the proposal is to provide rehabilitation following a multi-disciplinary team approach with physiotherapy, occupational therapy and social care being provided by a community service. The proposal includes medical review of complex patients within a multi-disciplinary team environment and the aim is that this would also include a community geriatrician service and where complex investigations are needed, these would be requested through secondary care (for example, tilt table testing and imaging). It is proposed that close links with primary care on prescribing and medicines management would support the service model and support for nursing services such as continence care and dietetics support would be provided through community services. The delivery model will exclude stroke patients where those stroke patients will be cared for by the specialist stroke community service.
Neuro Assessment Service/Brain Injury Service/Neuro re-ablement	Current Service	There are currently 3 services provided at NUH which serve very similar patient groups: • Neuro assessment service – this provides outpatient services for patients who have a neurological diagnosis, are under the care of a consultant physician and have specific treatment goals. Specifically the service provides assessment of clinical and psychological needs, identifies and treats or manages problems, and helps co-ordination of services to achieve an integrated, seamless and cost-efficient plan to achieve rehabilitation goals and care. • Brain injury service – this provides an outpatient service for patients who have had a documented Glasgow Coma Scale Score of 12 or less for at least 30 minutes which requires admission to hospital, and a definite, documented, traumatic brain injury. Specifically it provides interdisciplinary assessment and treatment to patients who present with complex physical and/or cognitive deficits resulting from neurological conditions and who require on-going

		therapy. Patients are offered an appointment for an initial assessment which results in the patient's goals/focus for neuro rehabilitation and professionals required being identified • Neuro re-ablement - this service is designed to rehabilitate and enable patients for a wide range of conditions following their admission to hospital. Specifically it facilitates complex discharges and promote earlier discharges , provides rehabilitation in the patient's home, and provides specialist neurological rehabilitation for a wide range of conditions
	No. of Patients or Contacts*	TBI 72 (new patients per year 35-40)/Neuro Assessment 276/Reablement 46
	Proposal	The proposal is to commission a community based neuro rehabilitation service with the aim of providing the same services and patient outcomes that are currently provided. The proposal aims to provide a high quality, equitable specialist community neuro-rehabilitation service to reduce the impact of both physical and psychological impairments, maximise independence, reduce mortality and prevent avoidable complications. The proposed service includes assessment of patients who are referred and confirmation through a multi-disciplinary team whether the patient requires interventions for 16 weeks in relation to a long-term neurological condition or 12 to 14 months for a traumatic or acquired brain injury. It is proposed that where clinically appropriate for the service, patients will commence on a 16 week or 12 to 14 month community treatment and rehabilitation programme provided by a multi-disciplinary team. It is proposed that the service provides each patient with a senior expert clinician as their case manager who will oversee the delivery of the plan It is proposed that by bringing together services that are currently delivered separately there is opportunity to review the overall staffing levels and skill mix whilst still ensuring high quality services are delivered. The aim is that patients will receive intensive but time limited rehabilitation after which they will be referred to community services for the continuation of the rehabilitation programme if required.

		The proposal includes patients being seen in community clinics and their own home. The proposal takes into consideration delivering care against patient need.
Dietetics	Current Service	Nottingham University Hospitals (NUH) provides a Dietetics Outpatients service which treats adults and children. The aim of the service is to treat the nutritional consequences of disease through a variety of nutritional interventions. For many of the pathways, patients are seen as part of the multidisciplinary team (MDT) clinic and are generally seen on the same day as the Consultant and other members of the team. In other cases, where a dietitian does not sit in the MDT clinic, referrals are managed in a stand-alone clinic or when they come to NUH for their treatment. The service also offers telephone contacts to appropriate patients. The service accepts referrals for the following conditions/ reasons renal, diabetes, obesity, cancer, HIV, Cystic Fibrosis, Gastroenterology conditions (e.g. Coeliac Disease), Paediatrics specific conditions (Metabolic, Allergy, Failure to thrive).
	No. of Patients or Contacts*	To be confirmed
	Proposal	In addition to the NUH dietetics service, there is also a community dietetic service provided by Community Health Partnerships. They may see patients for similar conditions and provide community based clinics, group sessions and home visits. Due to the nature of long term conditions managed by the Dietetics Outpatient team, service users may vary between requiring specialist management within secondary care, and when more stable could be managed within the community setting, closer to home. At present, it is difficult to flow between the two services and settings. Therefore the proposal is for a single provider (or group of providers working together) to provide an integrated dietetic service to deliver all non-inpatients dietetics. The proposal is for an integrated dietetic service with the aim that it will provide the following: • A structured and consistent approach to dietetic management through multidisciplinary working, promoting effective and integrated working relationships with the clinicians within the acute setting, community services and Primary Care.

		• The aim that the most appropriate clinician, setting and intervention are identified and offered at the outset of treatment. This is reviewed during the patients care and is adjusted as clinically appropriate. • A movement towards specialist staff delivering services closer to home and up-skilling of community staff to see a more complex case mix. • A broader offer of delivery methods, to include group sessions, improved access to self-care information and greater use of technology.
Orthoptics	Current Service	Orthoptics is an ophthalmic field relating to the treatment of patients with disorders of the visual system with an emphasis on binocular vision and eye movements. The following are some of the conditions all treated by orthoptists: • Strabismus (Squint) • Amblyopia (lazy eye) • Refractive Errors, such as astigmatism (problem with focusing of light and blurred vision) • Myopia (near sighted) • Hyperopia (far sighted) • Low vision (visual problems that is not correctable through surgery, medicines, glasses or contact lenses) The service assesses diagnoses, manages and treats vision disorders for people of all ages in order to enhance visual performance and relieve symptoms.
	No. of Patients or Contacts*	13,184
	Proposal	The proposal is that there could be an orthoptic community service which provides services for patients who do not require emergency care for their condition. The proposal is that the service will assess and treat people of all ages from babies to adults. It is proposed that the service will be provided by orthoptists and optometrists who are skilled in caring for people with a range of eye conditions. It is proposed that the service will work closely with the hospital to provide seamless care and access to hospital specialists as required and according to patient need. It is proposed that pathways between the community and hospital service are clinically designed and monitored to ensure access to care is timely. All emergency eye conditions that need treatment on the same day will continue to access the services provided by eye casualty at the QMC hospital site.