

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	1
Service	Kirklees Care Home Support Team
Commissioner Lead	Greater Huddersfield Clinical Commissioning Group North Kirklees Clinical Commissioning Group
Provider Lead	
Period	
Date of Review	

<p>1. Population Needs</p> <p>1.1 National/local context and evidence base</p> <p>This service specification covers patients living in both residential and nursing homes across Kirklees and who are registered with general practices within the Greater Huddersfield and North Kirklees Clinical Commissioning Group boundaries.</p> <p>Within the Greater Huddersfield boundary there are approximately 73 registered care homes that cater for older people, clients with disabilities, those with mental health problems, and clients with learning disabilities. This service specification covers the 39 Older People Care Homes with a total anticipated bed base of approximately 1,630.</p> <p>Within the North Kirklees boundary there are approximately 47 registered care homes that cater for older people, clients with disabilities, those with mental health problems, and clients with learning disabilities. This service specification covers the 29 Older People Care Homes with a total anticipated bed base of approximately 1,185.</p> <p>This means there are currently a total of 68 Older People Care Homes covered by this specification and a total anticipated bed base of approximately 2,815. These numbers will vary; any new homes that establish in the Kirklees area within the duration of this service contract will be covered by this specification; to this end the ability to flex capacity is fundamental.</p> <p>The Kirklees Care Home Support Service therefore excludes those care homes for people with Mental Health; Physical disability or learning disabilities, which fall outside the scope of this service specification.</p> <p>The Care Homes covered by this service specification are those registered to provide either residential care or nursing and residential (dual registered) care. The dual registered homes employ qualified staff to care for/oversee the care of their nursing status clients.</p> <p>The funding of clients in Care Homes is either through Kirklees Council or other out of area authorities, self-funding or, for nursing status clients, partially or fully funded by the NHS. Due to an ageing population and clients being cared for in their own homes for longer, there are now more residents within Care Homes who have continuing health or end of life needs. As a result the health care needs of this client group is often complex, and requiring</p>

a multi-disciplinary / multi professional approach.

The Kirklees Care Home Support Team will be pivotal in helping to drive change, working collaboratively with local healthcare Providers and stakeholders to plan for, and co-ordinate on-going health care with the primary aim of keeping individuals well and/or stable, to reduce the need for out of hours hospital attendance / hospital admissions. This approach will be underpinned with robust care planning to ensure all care is optimised, delivered in the care home, and wherever possible, avoiding a hospital attendance or admission.

Dementia

The term 'dementia' is used to describe a set of symptoms which result from the ongoing deterioration of the brain, caused by a number of diseases in which there is a progressive decline in multiple areas of function, including memory, reasoning, communication skills and the ability to carry out daily activities. There are individual differences in the speed and progression of dementia; people may live with it for up to 15 years after diagnosis, but it is a terminal illness. Each person is unique and will experience dementia differently.

In 2012, the Department of Health prioritised dementia through the Prime Minister's Dementia Challenge (Department of Health (DH), 2012). The challenge was to diagnose earlier, drive improvement in care, create dementia friendly communities and improve research. This vision will be updated with the publication of a new domestic policy on dementia to 2020 (Alzheimer's Society, 2014a). Nationally, it is estimated that 1 in 20 people over the age of 65 years are affected by dementia and 1 in 5 people aged over 80 years. By 2030 it is estimated that this will have increased by more than 60%. In Kirklees it is estimated that nearly 1 in 16 (4,800) people aged over 65 had dementia in 2015, and that this is projected to rise to nearly 5,500 or 1 in 14 by 2020 (4). It is estimated that there are over 100 people locally with young onset dementia, i.e. aged under 65 years, and this is expected to increase slightly to around 110 by 2020^(JSNA).

Research has highlighted there may be in excess of 80% of people living in care homes with a diagnosis of dementia or cognitive impairment (Alzheimer's Society, 2013). Establishing appropriate pathways for assessment, referral to memory clinic and diagnosis of dementia is important when people are living in care homes. According to NHS England and NHS Improving Quality (2014) there has been a high take up of the Dementia Enhanced Service (DES). The Dementia Enhanced Service Specification helps GP practices to take a proactive approach in assessment of people who may be at risk of dementia. Identifying residents at clinical risk of dementia, offering assessment and referral to the memory clinic where dementia is suspected. However, for people with more advanced undiagnosed dementia living in care homes there needs to be an alternative pathway to diagnosis. The Alzheimer's Society (2010) acknowledges referral to a specialist team is the most appropriate route for a dementia diagnosis; however it may be that a specialist nurse or GP can make a diagnosis.

The Department of Health (DH) (2014) suggests that primary care is 'critically placed' to provide an increased role in assessment and treatment of dementia. There will always be residents who decline to attend memory clinics and there are residents who have deteriorated 'beyond the point' where they may be able to attend a memory clinic. Furthermore, most GP practices have residents who are dying with 'undiagnosed' dementia. Thus, a diagnosis of dementia for a resident in a care home can prompt reviews, such as for end of life care and prevent hospital admissions (DH, 2014).

Current guidelines require that primary care clinicians annually review both the physical and mental health needs of residents with dementia who are registered with their practice (NICE

2007). Evidence suggests that although the number of people in the UK recorded as having a review is high, the quality of these reviews is on the whole, suboptimal. Connolly et al. (2012) report only 51% and 61% of reviews incorporating a social care review or a discussion with the patient's carers.

NICE quality standard 50, Mental wellbeing of older people in care homes, recognises that residents may have more than one mental health condition at a given time. These include common mental health conditions such as depression, generalised anxiety disorder and social anxiety disorder, and may also include delirium. (See the NICE guidelines on dementia (NICE clinical guideline 42), depression in adults (NICE clinical guideline 90), depression in adults with a chronic physical health problem (NICE clinical guideline 91), delirium (NICE clinical guideline 103), common mental health disorders (NICE clinical guideline 123) and social anxiety disorder (NICE clinical guideline 159) for more information.

As an integral component of Kirklees Health and Social Care integrated system, the Kirklees Care Homes Support Team is ideally placed to take the lead in the delivery of coordinated and enhanced service for residents and their families living with dementia.

End of Life

Residents are 'approaching end of life' when they are likely to die within the next 12 months. This includes residents whose death is imminent (expected within a few hours or days) including those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events

NICE recommend that this group of people should receive consistent care and the Kirklees Care Home Support Team will endeavour to ensure that this is coordinated effectively across all relevant care settings and services, by practitioners who are aware of the person's current medical condition, care plan and preferences.

End of life care requires an active compassionate approach that treats, comforts and supports individuals who are living with or dying from progressive or chronic life threatening conditions. Such care is sensitive to personal, cultural and spiritual values, beliefs and practices and encompasses support for families and friends up to and including the period of bereavement, during which time the Kirklees Care Home Support Team signpost relatives appropriately for their needs.

Telemedicine

There is a growing evidence base (Kings Fund 2010 and more recent) that increasing numbers of vulnerable elderly residents, particularly in care homes, are admitted to an acute hospital bed when alternative, more appropriate care could be provided at home or in their nursing/residential care home.

Supporting these residents to remain within their home improves the patient experience, avoids lengthy hospital visits, reduces the risk of them being exposed to hospital acquired infection and hospital based falls, all are more prevalent amongst this patient group.

LOCAL HEALTH NEEDS IN KIRKLEES:

The following health needs relate to the resident population of Kirklees as a whole. This service specification covers residents in Greater Huddersfield and North Kirklees who fall within the commissioning boundaries of NHS Greater Huddersfield Clinical Commissioning Group (GHCCG) and NHS North Kirklees Clinical Commissioning Group (NKCCG).

All people who permanently reside in a care home are classified "Frail".

Based on information from the Kirklees Joint Strategic Needs Assessment (JSNA), **frailty** can be defined as multiple co-morbidities accumulating with increasing age leading to a gradual decline and regular exacerbations before a person's last days.

Frail residents living in the care home environment are a high need, protected client group whose average life expectancy after taking up permanent residence in a care home is 18-24 months. Therefore, demand on health services is continual. There is high prevalence of multiple co-morbidities, such as heart disease, respiratory disease, diabetes and dementia, as well as common ailments associated with the elderly, specifically as a result of a fall, urinary tract infection, respiratory problems/pneumonia, constipation etc.

For Greater Huddersfield life expectancy at aged 65 years is 83.0 years for men and 85.9 years for women. Male and female life expectancy at birth in Huddersfield have both increased by 2.5 years in the last 10 years. More than two in five people aged 65 years or over suffer from three or more long-term health conditions. Over one in four people aged 65 years or more has fallen and hurt themselves in the last 12 months.

In North Kirklees life expectancy at birth is 79.0 years for men and 82.1 years for women. Male and female life expectancy at birth in North Kirklees has both increased by 3.1/2.4 years respectively, in the last 10 years. Around two in four people aged 65 years or over suffer from three or more long-term health conditions. Over one in four people aged 65 years or more has fallen and hurt themselves in the last 12 months.

In Kirklees as a whole two in three (68%) of adults had a long term condition, more than half of these (54%) had more than one condition and one in eleven (9%) had four or more. Living with more than one long term condition increases impact on personal functioning and the level of support needed.

People often struggle to discuss the sort of care or location of death they would prefer, and few people are clear about the options that might be available to them or their family members. Most people in Kirklees die in hospital, although many people say they would choose to die at home or elsewhere.

Around 0.29% of all Kirklees patients are on a GP practice Quality Outcomes Framework (QOF) "end of life" register, the same as regionally and nationally. This should be higher as around 1% of a GP practice population is likely to die on average each year i.e. meet the "3 trigger criteria" for inclusion on a register. This suggests that adults nearing the end of life diagnosed with chronic long-term illness are not gaining access to end of life care.

There are more than 67,000 people aged over 65 years living in Kirklees, 1 in 6 of the total population. By 2030, 1 in 5 Kirklees people will be aged over 65 years. The over 85 population will rise even more from 8,300 to 14,800 by 2030, an increase of 78%. These are the people most likely to have complex health and social care needs.

The health challenges for older people are different to those of working-age adults. The biggest are disability and frailty, falls, pain, incontinence, dementia, depression and obesity along with poor diets and physical inactivity.

Care Home Engagement:

As part of the scoping for the Kirklees Care Home Support Team model the following engagement took place within the CCG areas:

Greater Huddersfield Communication Teams surveyed Care Home Residents & Staff and found:

- The majority of residents (74%) interviewed no longer saw the same GP they used to have prior to coming to live at the Care Home. For those who did still see the same GP (24%) this was because the care home was in the same area they used to live and so this did not change.
- The majority of residents (75%) were happy with the proposed change of primary care provider, and reassured there would be better continuity of care.
- Care Homes staff told us that on occasion they experienced difficulty registering patients, and difficulty getting a home visit.
- Care Homes staff told us that with better communications, routine visits and technology residents would be better cared for and less A&E visits would be required. This was because sometimes for minor problems reassurance was needed, but consultation with the resident was required to achieve this.

Other Patient Feedback that informs all Greater Huddersfield Commissioned Services include:

- I'm seen at the right time by the right person
- More of my care happens nearer to where I live
- Me and my carers know how to manage my health and wellbeing
- Everyone involved in my care knows my story
- My risk of being admitted to hospital is reduced

North Kirklees Communication teams worked with Healthwatch Kirklees to undertake a survey with care home staff, residents, families and general practice detailed in a report which summarises the engagement and feedback. The survey asked opinion around the following areas:

- Proactive/anticipatory holistic assessments and care planning
- 24 Hour Telehealth
- One GP practice per care home
- Good End of Life Care
- Education – Primary Care and Care Homes

14 of the 27 practices responded to the GP questionnaire. Healthwatch visited 12 homes and overall responses were received from 16 of the 29 homes. In total 230 completed public surveys were received. Of these 35.8% (79) were from care home residents; 16.3% (36) from families / carers; 36.2% (80) from care home staff; and 2.7% (6) from Voluntary Community Sector (VCS) organisations.

- **Regular health and wellbeing reviews**

There was overwhelming support from the respondents to both the public survey (89.8%, 167) and GP practice survey (88.9%, 16) for the proposal to introduce regular health and wellbeing reviews.

- **Telehealth**

Overall, 72.4% (139) of respondents to the public survey thought telehealth was a good idea. When this was analysed by the different groups, 78% (58) of care home staff thought it was a good idea, 64% (48) of care home residents and 68% (22) of families / carers, and 50% (9) of responses from GP practices. Care home staff were more supportive of the idea and could see the benefits to both GPs, care home staff and residents.

- **One GP practice per care home**

Overall, 58.1% (125) of respondents to the public survey thought one GP practice per care home was a good idea. When this was analysed by the different groups, 69% (52) of care home staff thought it was a good idea, 48% (38) of care home residents and 56% (18) of families / carers. Most care home staff felt that it was a good idea, as it would improve relationships between the care home and GP practice, and improve the quality and continuity of care.

- **End of life care**

A question around the proposal of good end of life care was only asked in the GP practice survey. Of those that responded, 87.5% (14) supported the idea. They thought that it was a vital part of care planning, and that the residents' GP is best placed to co-ordinate the residents' care.

- **Education**

A question around the proposal of education in primary care and care homes was only asked in the GP practice survey. Of those that responded, 83.3% (15) supported the idea.

This specification is sensitive to the outcomes from both CCGs engagement processes and any future Provider will consider these points when planning and implementing services.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

Kirklees Care Home Support Team Patient Identified Outcomes which apply to all commissioned services:

1. I'm seen at the right time by the right person

2. More of my care happens near or nearer to where I live
3. Me and my carers know how to manage my health and wellbeing
4. Everyone involved in my care knows my story
5. My risk of being admitted to hospital is reduced

SERVICE SPECIFIC OUTCOMES:

1. Deliver high quality of care that will keep Care Home residents as well and stable for as long as possible, preventing de-conditioning
2. Deliver a seamless experience for the service user, without overlap or duplication.
3. Through robust care planning, significantly reduce clinical variation & the reliance on hospital based services, including good End of Life Planning and Care.
4. Ensure prescribed medications are up to date and relevant to the patient's holistic need.
5. Reduce the reliance on hospital based services (planned and unplanned).
6. Reduce the risk of falls or other harm that may result in a hospital attendance or admission.
7. Champion a "food first" approach wherever possible avoiding residents relying on nutritional supplements.
8. Ensure high quality End of Life care.
9. Maximise the use of technology to enhance patient care and deliver efficient and cost effective services, thereby reducing the reliance on Emergency Hospital Services.
10. Support the implementation of aligned care home schemes such as: Red bag scheme; Bed state tool; Access to SystmOne/EMiS online records; Trusted assessors; NHS England Pharmacy scheme etc.

Dementia

Support the delivery of:

1. Increasing the diagnosis rates of dementia
2. Maintaining an up to date Dementia Register
3. Early identification of residents at clinical risk of dementia
4. Assessing for the signs of dementia
5. Providing an appropriate and timely diagnosis, which may be undertaken within the Kirklees Care Home Support Team or via referral to the Memory Assessment and Treatment service (MATs), as deemed clinically appropriate
6. Ensure appropriate care plans are in place; this may include an advanced care plan.
7. Care plans are reviewed at least annually and with greater frequency depending on the changing needs of the patient.
8. Supporting the patient's family/carers
9. Developing a specific and commissioner approved Dementia Pathway with whole system links
10. Securing Dementia Friendly status

From a local and national statistical point of view improving dementia prevalence will assist in driving changes for future planning of services and increase the number of people recorded as dying with dementia.

End of Life

1. All End of Life residents have an agreed advance care plan in place, including DNA CPR form as appropriate
2. Wherever possible, the patient dies in preferred place of death
3. 100% use of EPaCCS system to ensure that residents story and wishes and known

to those around them who provide care including Out of Hours (OOH) and emergency services

4. Carers and Family Experience are included in any decision making process

Telemedicine

1. Improves Clinical Outcomes and Quality of care for our residents, and promotes independence
2. Enhances Care Closer to Home
3. Supports local service transformation programmes by reducing the reliance on hospital based services
4. Delivers Value for Money by reducing clinical variation

3. Scope

3.1 Aims and objectives of service

A new service model has been developed to deliver primary care into all our Older People Care Homes as articulated in the diagram below. The main elements of the model will be delivered by the Kirklees Care Home Support Team who will have the ability to register residents for GMS services. However, practices may wish to retain patient registration and work collaboratively with the Kirklees Care Home Support Team to deliver the required care.

Figure 1 – Kirklees Care Home Support Team - Functions

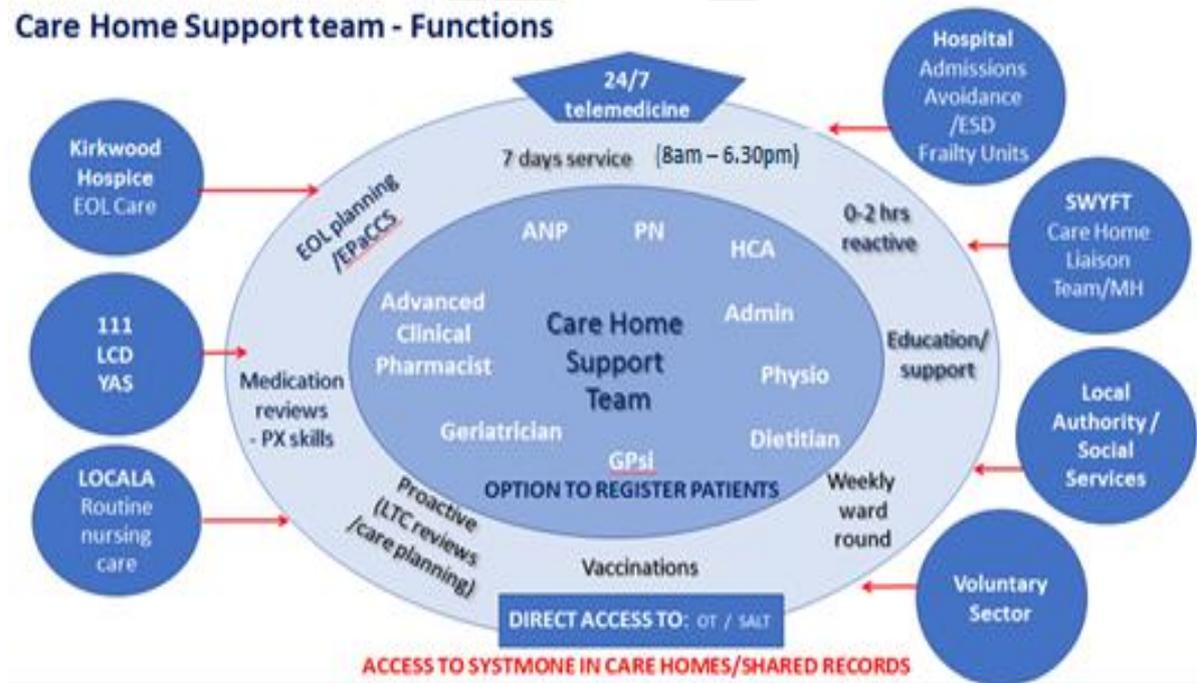


Figure 2 – Functions of Registered GP/ Kirklees and Care Home Support Practice (registering residents)

1 Care Home = 1 Practice (+ central registration overflow)

FUNCTIONS		
Registered GP	Care Home Support team	Care Home Support Practice
Urgent advice/visits	7 day service 8am – 6.30pm	Overflow for central registration
Repeat prescribing	0-2 hours reactive urgent response	Urgent advice/visits
Path lab results	Weekly ward round	Repeat prescribing
Monthly joint reviews / MDT	EOL/EPaCCs	Path lab results
	Annual proactive holistic review (including LTC and medication reviews / QOF & Care Planning) - Review < 2 weeks of hospital discharge - Review on admission to care home	Monthly joint reviews / MDT
	Vaccinations (Flu/Pneumonia/Shingles)	
	Care Home education & support	

Where the patient is registered with the Kirklees Care Home Support Team practice, the practice element of the team will provide the core GMS services / registered GP functions alongside monthly joint MDT reviews, in addition to the Kirklees Care Home Support Team functions outlined in figure 1 and 2 above.

An MoU may be required to support and define ways of working between Care Home Support Team and General Practice, where practices have retained registration for Care Home residents.

Figure 3 below defines the delivery expectations where an MoU is and is not in place.

Figure 3 – Functions delivered where MoU is / is not in place

<p>Registered GP / CHST registration Service provided to Patients covered by MoU**</p> <p>Urgent Advice / visits Monthly MDT Pathology Results Repeat Prescriptions Remaining essential GMS services (as defined by GMS Contract) <i>**registered GP could be either individual GP Practice or CHST GMS function</i></p>	<p>CHST Service provided to Patients covered by MoU</p> <p>24/7 telemedicine 7 day service 08:00 – 18:30 0-2hr reactive care Proactive LTC reviews / care planning Weekly ward rounds <u>EoL planning / EPaCCS</u> Medication reviews Education & support to care home staff Vaccinations Direct access to OT / SALT</p>
<p>Registered GP Service provided to Patients NOT covered by MoU</p> <p>Continued delivery of existing GMS services</p>	<p>CHST Service provided to Patients NOT covered by MoU</p> <p>24/7 telemedicine</p> <p>Education and support to care home staff (where the care home support team is supporting other residents in the same care home which are covered by the full Care Home Support Team Service detailed above)</p>

The Kirklees Care Home Support Team will deliver the following functions:

- **Proactive/Anticipatory care**, including timely holistic assessments, medication reviews, Long Term Conditions management, routine vaccinations (Flu, Pneumonia, Shingles) as required by the GMS and APMS contract, with a focus on maintaining stability and minimising the risk exacerbation and/or other issue resulting in a hospital attendance or admission.
- **Early Supported Discharge and Admission Avoidance** to minimise any disruption to care home residents. Admission avoidance will be supported through a 0-2 hours triage/reactive response. Good integration with the local health system will be imperative, including working with both the local Acute Hospital Trusts and other system partners to integrate with their Frailty services.
- **Education** to care homes as required to improve the quality of care provided to residents, and to ensure that all local pathways are adhered to. The level of education currently provided to care homes will be included in the service specification for this service to ensure that quality of care is equitable across all care homes. In addition the Provider will be a point of reference to general practice in the primary care management of the frail and elderly.
- Provide, embed and maximise **telemedicine/telemonitoring** in all care homes to support the day to day delivery of services and provide efficient and effective care in

a timely manner. Through the use of digital technology and robust integration with the local health system, facilitate 24/7 rapid access to expert clinical assessment and support to reduce the reliance on hospital based emergency services.

- Provision of good quality **End of Life care** which is robustly integrated with other Providers in our local health system and contributes to the completion of EPaCCS.
- **Streamlining of general medical services** - the evidence-base tells us that streamlining the number of practices with registered patients in care homes reduces duplication, provides a consistent approach, builds relationships and improves communication. The model therefore is built on a '**one practice to one care home premise**'. The provider will be expected to work with Care Homes and Practices to facilitate and support streamlining. It is acknowledged that some practices may wish to continue to keep a list of registered care home patients, whilst others may wish to reduce or no longer hold a list of registered care home patients. Patient Choice will take precedent. Therefore Practices who no longer wish to register care home patients will not be able to remove existing residents from their lists and will be required to continue to provide care. Practices can only remove existing patients who move into a care home if they move outside of a practice boundary or it is the patient's choice to move.
The Provider will work with Practices, Care Homes, Patients and their families to provide a smooth transfer of registration.
The Kirklees Care Home Support Team Provider requires the ability to register patients for general medical services and should be CQC registered.
- **Access to SystemOne/EMiS** - the Kirklees Care Home Support Team and the registered GP will access the patient record whilst on site in the care home environment to ensure safety through use of mobile technology with clinical system connectivity. To ensure optimal care, sharing agreements and appropriate digital processes will be followed in-line with data protection; Caldicott and GDPR. Care will be documented in a way that supports access from Kirklees Care Home Support Team; GP; Care Home; patient and relatives.
 - In addition, care home staff will be supported to access patient records either via SystemOne/EMiS on-line or an alternative method (with appropriate patient consent). Sight of the on-line record will enable care home staff to access prescriptions, shared care plans and basic patient information which will assist in individualised care planning within the home.

The Kirklees Care Home Support Team will provide domiciliary visits (as a minimum) via weekly "home round" in every care home. The service will provide care to all temporary residents. All Kirklees Care Home Support Team patients will have a robust care plan (including special person notes) and any DNR/CPR plan in place that will be reviewed and updated in a timely fashion, and will be available to other care Providers in our local health system via a fully integrated clinical IT system.

The Kirklees Care Home Support Team will be delivered by a multidisciplinary (MDT) team consisting of GPs; Geriatrician; Advanced Nurse Practitioners, Practice Nurse/LTC review nurse; End of Life Nurse, Advanced Clinical Pharmacist, Physiotherapist /Occupational Therapist; Dietitian, and Health Care Assistants and administrators who will provide high

quality GMS tailored to this protected client group. Direct access to Speech and Language therapy will also be required.

Dementia

The Kirklees Care Home Support Team will, by working in partnership with care home, health and social care partners and the families/carers of patients, provide a high quality consistent level of dementia care across local care homes, by delivering effective diagnosis and ongoing care and support.

End of Life Care

The aim of the service is to enable those with end of life care needs to maintain their identity and independence, whilst also supporting their family, friends and carers during the changing phases of their illness. The focus of the service will be to improve the quality of care for residents at the end of their life. The Kirklees Care Home Support Team will adopt a multi-disciplinary approach internally to ensure that services provide complex symptom management and holistic care with the aim of ensuring that residents have the optimum quality of life until death. It will achieve this by working collaboratively across primary and secondary care to facilitate choice in respect to preferred priorities for care and death and this will contribute towards reducing avoidable hospital admissions and reducing length of stay. The service will support individuals and their families so they can make informed choices about treatments, management of care, End of Life Care including all palliative, current and future care needs. Interdependent with the specialist services provided by Kirkwood Hospice.

The objectives of the service are as follows:

- To work within an integrated, high quality, patient centred and coordinated end of life care service
- Provide clinical assessment of patient needs
- Deliver effective individualised advance care planning for residents approaching end of life
- Enable people to be treated and die in their preferred place of care
- Reduce A&E attendance and unnecessary hospital admissions for residents approaching the end of life, where possible
- Ensure effective communication with all partners and agencies involved in the care of residents, most significantly the patient, their carer and family
- Support and facilitate the Gold Standard Framework and multi-disciplinary team meetings where appropriate
- Ensuring residents that have a care plan have their preferences and choices reviewed during MDT meetings
- Support residents, carers and their families holistically throughout the life of the patient and signpost to services accordingly following death
- Actively participate in the use of the EPaCCS system for all residents who are in the last year of life to promote effective communication
- Review on an annual basis the process for issuing and completing statements of intent

Telemedicine

The Kirklees Care Home Support Team includes the provision of a 24/7 Telemedicine solution to all Care Homes, within the Kirklees area. NHS England in its Five Year Forward View alludes to the Airedale Hub Service; this is not prescriptive however, and the Kirklees Care Home Support Team will have the autonomy to select a technical solution of its choice to assist in the achievement of the desired outcomes and key performance indicators.

- Enables a person to remain safe and secure in his/her own home for as long as possible
- Integration of technology to support residents with long term conditions
- Avoiding unnecessary activity across all care settings
- Prevents avoidable hospital admissions
- Increases the number of people being cared for and dying in their usual place of residence (UPR)
- Decreases the number of call to YAS and conveyances

The Provider will include the most appropriate system to deliver their service complying with data protection and network security requirements. The commissioner anticipates that the use of telemedicine/telemonitoring will be appropriate for the needs of the target population; this may include specific disposition pathways. The commissioner expects Information Governance requirements to be addressed as part of the patient consultation set-up to ensure patient's confidentiality is protected and there is consistency in recording the consultation in the patient records.

3.2 Service description/care pathway

The Kirklees Care Home Support Team practice will provide the following core functions:

- Urgent advice and /or visits as appropriate following 0-2 hour triage of the patient via Telehealth, taken any appropriate clinical advice from the GPs/other clinical colleagues and deem that urgent liaison with the patient's registered GP is required. Discussion with the GP will identify if an urgent GP visit is required.
- Manage repeat prescribing
- Manage pathology laboratory results
- GP to participate in monthly joint MDT meetings with the Kirklees Care Home Support Team at the care home, reviewing patients with an ongoing medical need

The Provider shall assess residents in line with the British Geriatric Society Fit for Frailty Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings 2014 (or latest version).

Following initial assessment which should include a comprehensive geriatric assessment within 2 weeks of registration, the Provider shall carry out an Assessment of Needs 6 monthly (or sooner if required) and develop a Personalised Care Plan in accordance with the individuals need and/or where appropriate including end of life.

The Provider shall conduct evidence-based medication reviews for older people with frailty (e.g. STOPP START criteria within 4 weeks of registration).

The Provider shall ensure that Services are provided through a Routine Team and a Reactive Team

The Provider shall ensure that the Routine Team:

- Is a multi-disciplinary team consisting of GPs, advanced nurse practitioners, practice nurses experienced in elderly care and managing long term conditions, clinical pharmacists, physiotherapist /Occupational therapist, dietitian and health care assistants and administrators
- Delivers a regular programme of planned weekly visits to all homes based on the needs of the residents.

- Undertakes proactive Admissions Avoidance work
- Proactive End of Life care and care planning
- Deliver monthly MDT review in all homes jointly with the registered GP and linking with the geriatrician for assessments / advice where needed

The Provider shall ensure that the Reactive Team:

- Is a multi-disciplinary team consisting of GPs, advanced practitioners, nurses, therapists and other clinicians suitably trained to deliver acute care to this client group
- Provides 0-2 hour triage / assessment supported by Telehealth for urgent issues and visit if required

The Reactive Visits shall be in addition to the Routine Visits. For Reactive Visits:

- The care home residents will be contacted within 0-2 hours to triage/assess the clinical need of the patient (24/7 hours a day via Telehealth)
- telemedicine will be utilised to facilitate triage, regular monitoring and speedy access.
- residents/carers/staff will be informed of the timescale in which they will be visited, and if the agreed visit is delayed
- visits will be made according to clinical need as determined by the primary care professional acting in accordance with Good Clinical Practice.
- advice will be sought from the registered GP should the team feel any further medical review is necessary
- the registered GP will assess the medical issue and arrange a home visit, where required

Appendix A details the pathway for 0-2 hour response for both practices which have signed up to the MoU and those that have not signed up to the MoU.

The Provider shall provide dedicated administrative support to the Kirklees Care Home Support Team (the Routine Team and the Reactive Team).

The Provider shall provide Kirklees Care Home Support Team services at such times, within Core Hours, as are appropriate to meet the reasonable needs of residents, including residents registered with practices as Temporary Residents.

The Provider shall have in place arrangements for residents to access such services throughout the Opening Hours if clinically urgent.

The Provider shall provide:

Essential Services required for the management of residents who are, or believe themselves to be:

- ill with conditions from which recovery is generally expected
- terminally ill
- suffering from a long term condition
- approaching End of Life

Referral onto other services as appropriate

Appropriate ongoing treatment and care to all residents taking account of their specific needs including:

- Advice in connection with the patient's health, including relevant health promotion advice
- Primary medical care services required in Opening Hours for the immediately necessary treatment of any person to whom the Provider has been requested to provide treatment owing to an accident or emergency
- Medicines Reconciliation

For the purposes of the above section, 'management' includes:

- offering a consultation and, where appropriate, physical examination for the purpose of identifying the need, if any, for treatment or further investigation
- making available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services and liaison with other Health Care Professionals involved in the patient's treatment and care

The Provider will ensure a coordinated falls service is offered to residents as per NICE CG161.

The Provider shall provide the following Services as defined in the GMS contracts regulations as Additional Services as amended from time to time.

The Services the Provider shall provide to residents are (but not exclusive):

- Vaccinations and Immunisations
- Phlebotomy
- ECG
- Spirometry

The Kirklees Care Home Support Team should aim to achieve all upper targets as set out by QOF, public health or local criteria i.e. upper 25th centile or as agreed locally.

Vaccinations and Immunisations

The Provider shall:

Offer to provide residents all clinically necessary vaccinations and immunisations including influenza, shingles and pneumococcal vaccinations, in accordance with "Immunisation Against Infectious Disease 2013: 'The Green Book' (as amended from time to time)

Provide appropriate information and advice to residents and, where appropriate, their carers/staff about such vaccinations and immunisations

Record in the patient's record any refusal of the offer of all clinically necessary vaccinations and immunisations

Where the offer referred to above is accepted, the Provider shall administer the vaccinations and immunisations, and include in the patient's record details of:

- the patient's consent to the vaccination or immunisation or the name of the person who gave consent to the vaccination or immunisation and his relationship to the patient
- the batch numbers, expiry date and title of the vaccine
- the date of administration
- in a case where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine
- any contraindications to the vaccination or immunisation
- any adverse reactions to the vaccination or immunisation

The Provider shall ensure that all staff involved in administering vaccines are trained in the recognition and initial treatment of anaphylaxis and any adverse reactions to the vaccination or immunisation.

Direct Enhanced Services

The Provider must consider all available Directed Enhanced Services, and provide as appropriate, including all vaccinations (including flu, pneumonia and shingles).

Locally Commissioned Services

The Provider must participate in all Locally Commissioned Services offered by the Commissioner, as appropriate to the patient population, over the term of the contract.

Opening hours

The Kirklees Care Home Support Team core hours will be: Monday to Friday between 08.00 to 18.30. Access to clinical triage/assessment will be available 24 hours a day/7 days a week through the use of telehealth.

This is the minimum requirement and there is nothing in this Agreement that prohibits the Provider from opening and providing services outside of these Core Hours.

The Kirklees Care Home Support Team shall undertake admission avoidance work, both proactive and reactive, at all times as part of the core service.

Provision of telephone access to Kirklees Care Home Support Team

The Provider must provide full telephone access to the Kirklees Care Home Support Team throughout the Core Hours 7 days per week.

Telephone access to Kirklees Care Home Support Team services will include, but not be limited to:

- Accepting/triaging urgent referrals
- Arranging non-urgent clinical reviews for new residents/those discharged from hospital
- Answering and co-ordinating patient/carer/staff queries and requests
- Signposting residents/carers/staff to services
- Coordinating / linking with the registered GP / Practice

Clinical reviews

The Provider shall offer a full range of consultation methods according to clinical need and patient/carer/staff preference including (as appropriate), but not limited to, telephone, e-mail and face to face / tele-consultation at the patient's residence.

The Provider shall undertake continuous assessment of its clinical review system and access, monitoring demand and supply and taking action to address gaps in provision.

For reactive care, carers/staff/ Kirklees Care Home Support Team are able to request urgent 0-2 hours clinical triage 24/7 hours a day.

For non-urgent reviews, Residents/carers/staff are able to book an appointment at the weekly ward round with the Kirklees Care Home Support Team or the monthly joint MDT with the GP and Kirklees Care Home Support Team.

New patient or post-discharge from hospital reviews will be arranged within 1 week of moving into/returning to the home.

Availability of Reviews

In order to ensure that demand for reviews is met, the Provider shall provide access, in line with the commissioners locally commissioned services and, as a minimum, ensure that a named Kirklees Care Home Support Team professional is available throughout core hours.

Length of Reviews

Appointment length shall be tailored to the clinical needs of the patient.

Punctuality of Reviews / telemedicine

Consultations shall commence within thirty (30) minutes of the scheduled visit time, unless there are exceptional circumstances.

Treatment for any patient suffering with immediate and life threatening conditions (as determined by a clinically trained individual acting reasonably) shall commence immediately as clinically appropriate

Urgent Visits to a Home

The criteria for determining when 'home' visits are necessary shall be consistently applied to residents.

The home shall be contacted within 0-2 hours and the patient clinically triaged followed by an urgent visit to the home, if appropriate.

Residents/Care Home Staff shall be informed of the timescale in which they will be visited, and contacted if the agreed visit is expected to be delayed

Home visits shall be appropriately indicated on the clinical system so that they can be audited

Improving Access and the Use of Technology

The Provider shall use a GPSOC approved systems in line with Greater Huddersfield CCG and North Kirklees CCG policy. They will sign the CCGs agreement in line with national expectations. The Provider will work with the CCGs on implementation of local strategy on Digital Primary Care schemes according to a timetable agreed with the Commissioner:

- Online patient access to records
- Online booking and cancelling of appointments
- Online ordering of repeat prescriptions
- Electronic consultations

The Provider shall proactively offer residents access to the services referred to in above, providing clear information necessary to do so.

The Provider shall issue passwords and verify the identity of residents wishing to access the services in listed above, as recommended by guidance from the Royal College of General Practitioners (RCGP).

The Provider shall ensure that its pages on NHS Choices and other websites are updated regularly, and at all times provide complete and accurate information regarding the service.

In addition to improving access through the use of technology, the Provider is expected to engage with Commissioners to achieve 7 day access as appropriate and in accordance with nationally and locally agreed arrangements.

End of Life Care

The Kirklees Care Home Support Team will facilitate and maximise specialist outreach services to facilitate care close closer to home, and will have an impact on reducing hospital admissions, support treatment in the residents preferred place of care and improve and standardise the quality of life and health outcomes for end of life care residents.

The responsibilities of the service will include, but are not limited to the provision of:

- Supportive care for families and carers
- Advance care planning, development and reviews
- Communication with other Providers
- The service must ensure a continual process of patient and family feedback and produce friends and family test results to be reported annually
- Receive feedback from care home staff where residents reside

Dementia

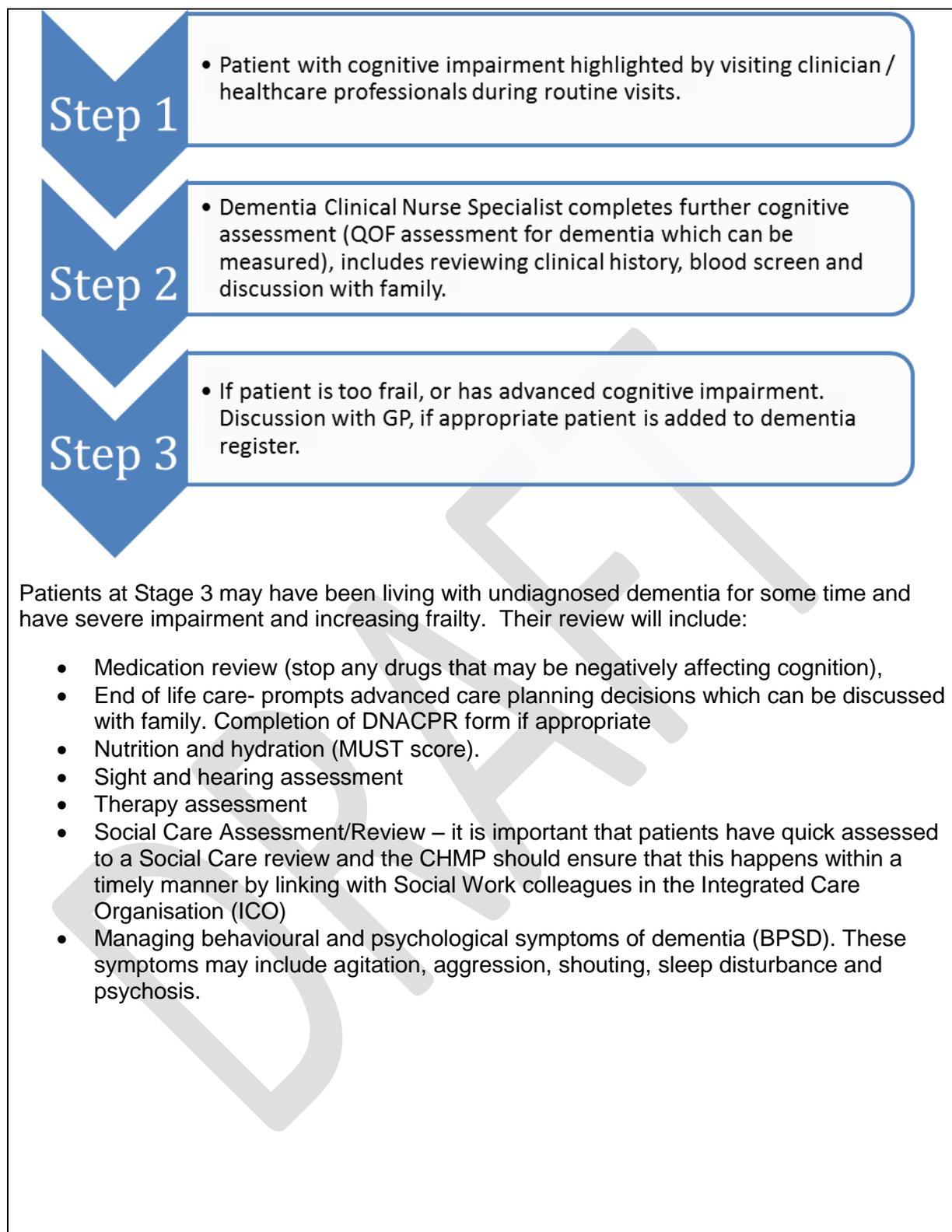
The Kirklees Care Home Support Team will identify patients with undiagnosed dementia through assessing cognition when patients register with the practice or when reviewed by visiting clinicians during weekly 'home rounds'. Patients will then be signposted to the Dementia Services for further assessment of cognition.

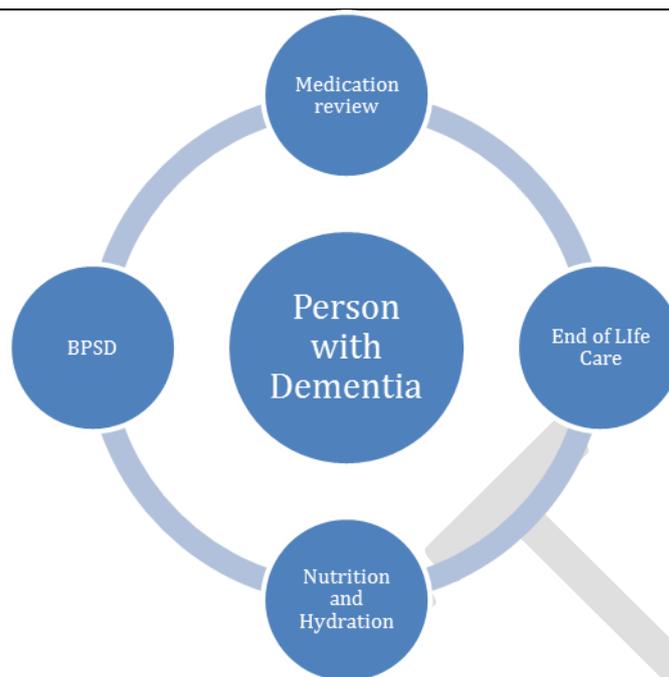
Diagnosis of dementia can be made by a clinician from the Kirklees Care Home Support Team after following appropriate guidelines (National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (NICE/SCIE) 2006 or most recent).

Suspected dementia patients will receive a comprehensive assessment consisting of history taking, cognitive and mental state examination (for example 6-Item Cognitive Impairment Test (6-CIT), a physical examination, a review of any drugs which may impair cognition and a blood screen. The assessment should where possible be carried out in the presence of the patients' keyworker in the care home.

Following diagnosis patients will be added to the QOF dementia register, a comprehensive management plan developed, including referral/s to appropriate services plus a review date.

Below are the 3 stages of the service:





It may be clinically inappropriate to refer patients at Stage 3 to the Kirklees Memory Services due to increasing frailty and the severity of cognitive impairment.

The Kirklees Care Home Support Team will ensure the ongoing primary care needs for patients with dementia are supported by:

- Delivering a comprehensive review of the needs of patients at least every 12 months.
- Provide information to any admitting hospital as requested by that hospital within 12 hours of the request.
- Undertake a post discharge assessment for patients who have returned to their care home, within 24 hours of the discharge notification, following a hospital admission
- Undertake regular review (as clinically appropriate) of patients on antipsychotic medication
 - Link with Acute Mental health services for advice and support on matters relating to mental health co-morbidities and escalation of mental health need.
 - Provide a rapid access service for dementia patients experiencing escalating needs
 - Support families, friends and carers to understand the impact of dementia on their loved ones.
 - Ensure the services of a Dementia Clinical Nurse Specialist are available; the nurse specialist will champion initiatives such as Dementia Friends.
 - Comply with prescribing guidelines, including medication reviews and provide audits in-line with Key Performance Indicators.
 - Provide support and information with regards to dementia to care home staff, this may take the form of the delivery of Dementia Training sessions in-line with Key Performance Indicators.
 - Ensure care home staff are supported to provide appropriate meaningful activities that provide appropriate stimulation to patients.
 - Hold a list of Dementia Leads within each of the care homes.
 - Ensure that advance care planning is carried out in line with local protocols
 - Ensure the end of life care needs are met
 - Work in partnership with all local Dementia care providers.

The Kirklees Care Home Support Team will support as required when considered clinically appropriate peoples participation in pilots and/or programmes these may include, research programmes, well-being programmes evidence based or innovation pilots.

3.3 Population covered

The Kirklees Care Home Support Service covers all patients living in CQC registered Older People Residential and Nursing Care Homes within the Kirklees boundary

Dementia

The dementia service, as described in this document is provided to all patients supported by the Care Home Support Team, living in CQC registered Older People Residential and Nursing Care Homes within the Kirklees boundary.

End of Life

All residents living in CQC registered Older People Residential and Nursing Care Homes within the Kirklees boundary supported by the Kirklees Care Home Support Team and who are believed to be in the last year of life and have end of life care needs.

Telemedicine

All residents living in CQC registered Older People Residential and Nursing Care Homes within the Kirklees boundary

3.4 Any acceptance and exclusion criteria and thresholds

An MoU may be required to support and define ways of working between Care Home Support Team and General Practice, where practices have retained registration for Care Home residents.

Where a GP practices has not signed up to the MoU the full range of Care Home Support Team Services will not be provided to those Care Home residents. See Figure 3 in section 3.1

Dementia

Any acceptance and exclusion criteria and thresholds, Care Home residents not registered with the Care Home Support Team

End of Life

Out of scope – residents not living in Kirklees Older People’s Residential and Nursing Homes and not in the last year of life.

3.5 Co-operation and Interdependence with other services/providers

The Provider will provide an integrated and fully supported primary health care team to work in partnership with all other NHS and non-NHS healthcare Providers and stakeholders (including, but not limited to, GP Out Of Hours (GPOOH), YAS, district nurses, social services, mental health services, the 111 service, acute trusts and acute trust laboratories, community health providers, other GP practices and healthcare providers and local voluntary and third sector organisations etc. provide) on the same basis as other GP practices in the CCGs area. This will include participating in any local collaborative models of working.

The Provider shall, together with the Commissioner:

Work with the registered practice to establish good information flows to/from pathology and diagnostic Providers and NHS and non-NHS healthcare Providers

Foster good working relationships and gain mutual understanding of systems, policies and procedures with key local stakeholders

Establish a directory of information regarding local resources and foster a good understanding of the local patient care pathways to promote effective signposting and referrals

Work to establish good working relationships with forums dealing with patient and Public Involvement (an NHS defined term) which is an initiative to involve residents and the public in the planning of services

Utilise specialist services (for example drug misuse, minor surgery, dermatology, NHS dentistry, NOUS, Ophthalmology) from central primary care locations and other services at local locations to avoid duplication of services, promote economies of scale, and bring practices together to plan and implement common aims for the benefit of those practices and their residents

The Provider shall collaborate with the Commissioner in the following areas:

Structures - to ensure that links are maintained with key individuals, departments, forums, and groups within the commissioning organisation, the relevant Network Neighbourhood/Cluster/Clinical Commissioning Group, Practice Manager Group, and the Practice Nurse Forum

Process – to ensure that similar policies and protocols are implemented by all Providers and the Commissioner (e.g. clinical policies, workforce planning including training opportunities and structured secondment programmes subject to agreement by the Commissioner and Department of Health)

Outcomes – to ensure that key clinical indicators are in place to allow benchmarking with other equivalent services commissioned by the Commissioner and contribute towards the Commissioner's own performance indicators

Education - to engage with training organisations (university and medical students) where applicable and provide a plan to continue.

The Provider shall:

Discuss and develop policies and procedures with local CCGs to ensure there is compatibility with local policies and procedures, including clinical and non-clinical issues, including the transfer of patients in / out of Kirklees

Sign up to multi-agency information sharing agreements as agreed with the Commissioner

Dementia

The provider will work with any organisation working in dementia within the CCGs boundaries and with any organisation working outside the boundary that provides dementia services to patients supported by the Care Home Support Team; to deliver an agreed

integrated dementia pathway, in line with best practice guidelines.

Listed below are various services/ providers, this is not an exhaustive list.

- Patients
- Care Home Staff
- Community Staff
- Specialist services
- Falls Service
- Dieticians
- Opticians
- Audiology
- Pharmacists
- Occupational Therapists
- NHS Funded Care
- General Practice
- Families, friends and carers
- Kirklees Dementia Action Alliance (DAA)
- NHS Greater Huddersfield CCG
- NHS North Kirklees CCG
- Calderdale & Huddersfield NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust
- Kirklees Council
- End of Life Team
- Physiotherapists
- Speech and Language Therapists
- Community and Religious Leaders
- Third Sector Providers

End of Life

The end of life care seamless integration to all relevant stakeholders including, but not limited to the following services:

- Locala District nurses
- Acute Trust Discharge Assessment Team
- Kirkwood Hospice Specialist Palliative Care Nurses and Admiral Nurse Service for people with advanced dementia
- Practice Nurses within Greater Huddersfield and North Kirklees
- South West Yorkshire Foundation Trust Learning Disability Team
- Kirklees Council Adult Care Services, Social Care
- Local Care Direct Unscheduled Care including GP out of hours
- Rapid Response/Intermediate Care Team
- Carer Services
- Safeguarding Adults Team
- Pharmacists
- Yorkshire Ambulance Service
- St John's Ambulance
- End of Life Care facilitators
- Other divisions of the local Acute Trusts

Telemedicine

- Out of Hours Services
- Yorkshire Ambulance NHS Trust
- Calderdale & Huddersfield NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust

3.6 Sub-contracting

The Provider must not assign, delegate, sub-contract or transfer any services to a material sub-Provider without Commissioner approval. The Kirklees Care Homes Support Team must take full responsibility for performance and management of the material sub-contract

and provide the Commissioner with assurances during the life of the sub-contract that is being managed. The Provider will abide by the rules of material sub-Provider within the NHS Standard Contract.

3.7 Equipment

The Provider shall provide all medical and surgical equipment, medical supplies including medicines, drugs, instruments, appliances, consumables and materials necessary for the delivery of services under this Agreement; which shall be adequate, functional and effective.

The Provider shall provide all non-medical equipment including Telehealth equipment and IT equipment and software and materials necessary for the delivery of services under this Agreement; which shall be adequate, functional and effective.

The Provider shall establish and maintain a planned maintenance programme for the equipment referred to in paragraphs 10.1 and 10.2 above in line with the manufacturer's guidance, and make adequate contingency arrangements for emergency replacement or remedial maintenance.

3.8 Referrals

The Provider shall:

Record all referrals in the patient record using the appropriate Read/SNOMED Codes and locally agreed referral templates

Monitor and minimise inappropriate referrals and hospital admissions in line with the commissioner annually agreed priorities and specific work plan

Comply with commissioner annual agreed priorities to minimise attendance at A & E and unplanned admissions

Co-operate with service Providers undertaking, Out of Hours services to ensure safe and seamless care for patients, including providing information on, as a minimum, a weekly basis and, where relevant, daily to such Providers carrying out, Out of Hours services on patients that may require their services or who have special clinical requirements

Provide complete and comprehensive information to support any referral made and comply with, where appropriate, any directions provided by the relevant commissioner concerning the format or composition of referrals including, where relevant, instruction to direct referrals to a third party for clinic booking and/or clinical triage

Use robust clinical pathways for referral, where these are agreed with other local healthcare Providers and/or issued by the relevant commissioner

Routinely collect and assess data about the appropriateness of the Provider's referrals, using audit and peer review to share learning

Implement national referral advice including Referral Guidelines for Suspected Cancer and NICE guidance

Ensure urgent suspected cancer referrals are received by the relevant Trust within twenty-four (24) hours

Review referrals practice every six (6) months as a minimum to ensure it is in line with latest guidance and protocols.

Develop and implement policies in relation to nurse, nurse specialist, Advance Clinical Pharmacist and Allied Health Professional referrals where they have an extended role in the treatment and investigation of residents with specified diseases

Implement and operate the e-Referral Service (e-RS) / TRISH at point of referral for services, and provide a booking facility unless this is managed by a third party under contract with the commissioner (in accordance with the NHS Choice agenda)

Follow agreed local pathways for referrals (OSCAR pathways for North Kirklees residents)

3.9 Human Resource Management – Provider Workforce Recruitment and Competence

The Provider must have a comprehensive, robust plan in place, for recruitment, selection and employment procedures, that are compliant with all applicable employment legislation and/or directives.

The principle objectives of the Provider must:

1. Reflect the local community and range of languages spoken to support access to services
2. Meet the essential day-to-day staff leadership, management and supervisory needs of the contract during its lifetime, including during mobilisation and, if appropriate, contract termination
3. Support the provision of safe, high quality clinical services
4. Ensure the appropriate skill mix: the intended range and ratio of clinical and non-clinical staff to include, but not be limited to, GPs, Advanced Practitioners, Practice Nurses, Health Care Assistants, pharmacists, Allied Health Professionals, Social Worker and other health professionals as required and the administrative staff required to support these professionals. Minimum staffing levels to be agreed with commissioners The ratio of whole time equivalent GP to weighted list size should be within the expected RCGP range.
5. Ensure that every member of the staff has a job description and appropriate contracts of employment setting out their terms and conditions, and roles and obligations as well as their rights
6. Ensure that, where appropriate any transference of employees to its employment must comply with TUPE regulations
7. Providers must specify arrangements to ensure that all mandatory pre-employment checks are implemented for all staff working in the organisation, including ensuring that all staff complete appropriate DBS checks before they start employment
8. Ensure, through appropriate audit, training and continuous professional development, that all staff involved in treating residents are and remain qualified and competent to do so
9. Support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice
10. Ensure there are systems in place to monitor that clinicians do not work excessive shifts or hours to the detriment of patient safety and their own welfare
11. Ensure annual appraisals are undertaken for all employed staff
12. Meet all mandatory training requirements
13. Undertake an annual staff survey

The Provider should provide details of their staffing structure highlighting the persons that are to have responsibility for the operation of the contract.

The Provider should provide details of the management structure and the escalation procedures for resolving problems. Also how, during periods of annual leave or sickness or an industrial dispute, the service will be delivered.

The Provider must ensure all Clinical Staff are registered with all appropriate regulatory bodies including without limitation the following:

1. For Medical Staff, the GMC
2. For Nursing Staff, the Nursing and Midwifery Council
3. For Staff who are other Health Care Professionals (including Allied Health Professionals, Health Care Scientists (where appropriate), Pharmacists, Therapists, Dietitians etc. are registered with the relevant professional body as outlined

All Medical Staff performing specialist procedures are suitably qualified, competent and experienced and are registered in the GMC Specialist Register in respect of the specialty in which they perform specialist procedures.

All GPs:

1. Are registered with the GMC and on the GMC GP register
2. Hold appropriate certificates confirming their eligibility to work in general practice including current membership on the Medical Performers List
3. Who are not already members of the Royal College of General Practitioners are encouraged to become members, having passed the MRCGP examination or obtained membership by Assessment of Performance
4. Are fully licensed to practice
5. Are engaged with appraisal and revalidation process
6. Have declared previous GMC suspensions and or conditions within the last five (5) years
7. Have declared suspension from performers list within the last five (5) years
8. Have adequate indemnity insurance cover

All Nursing Staff:

1. Are registered on the Nursing and Midwifery Council Register and, if they are to prescribe drugs and/or medicine, that the corresponding entry in the register indicated they hold a prescribing qualification
2. Are subject to robust procedures for monitoring of re-registration annually and revalidation for nurses
3. Have declared of previous NMC suspensions and or limitations within the last five (5) years

All other health and social care professionals:

1. Are registered on the relevant professional register for example Health and Care Professions Council register or General Pharmaceutical Council register, The Professional Association for Social Work and Social Workers etc.
2. Are subject to robust procedures for monitoring of re-registration and monitoring of such
3. Have declared any previous professional suspensions and or limitations within the last five (5) years

3.10 Workforce Training and Development

The Provider must ensure arrangements are in place to ensure that all clinical and non-clinical staff are adequately trained and are competent for their roles, including setting up systems for assessing clinical competence in telephone consultations and triage, and overall IT competence.

The Provider must have robust staff development processes in place including opportunities which will provide development for both clinical and non-clinical staff. This

might include formal qualifications, short courses and on-the-job training. All staff employed must receive an annual appraisal and hold a personal development plan.

3.11 Practitioner Skill Mix

The Provider shall:

Notify the Commissioner about any planned material changes to the skill mix of Clinical Staff within the Kirklees Care Home Support Team

Keep the Commissioner informed of any changes in the permanently employed primary care professionals

Take all reasonable steps to keep the use of locum GPs or nurses to a minimum.

Provide workforce data/sickness/vacancy rates etc. as required by the commissioner

3.12 Patient Registration

The Provider shall ensure that all persons residing in Older People's Residential and Nursing Homes undergo the following registration process:

- a) Practices have an open list and registers on request by the patient or their representative any patient residing in an older people care home within Kirklees, upon completion of a GMS1 (or GMS3 form for temporary residents, as appropriate).

3.13 Service monitoring

Full key performance indicators for the Kirklees Care Home Support Team will be agreed with the new provider following baseline assessment and include stretch targets over the 3 year contract period.

KPIs will cover the following areas:

- Number of proactive assessments on newly registered residents within 2 weeks of registration
- Number of post discharge assessments within 2 weeks of discharge
- Number of reactive assessments per month
- Number of proactive assessments per month
- Number of Medication Reviews completed per month
- Number of patients with an emergency care plan in place
- Number of discussions about advance care planning taken place per month
- % of end of life patients registered on EPaCCs
- Number of patients assessed for dementia
- Number of patients diagnosed with dementia
- Number of patients referred onto memory clinic
- Number of Falls assessments performed per month
- Number of falls each month
- Number of Dietetic assessments performed per month
- Number and type of educational sessions delivered
- Patient stories log to be provided each month
- Number people with urgent needs seen < 2 hours each month

- Number of GP requests for urgent advice
- Number of GP urgent visits
- Number of calls to telehealth service
- Number of ambulance calls
- Number of A&E Attendances
- Number of unscheduled hospital admissions
- Number of 0-1 days stays
- Length of stay in hospital
- Number of people dying in their place of choice
- Feedback from patients, relatives and carers
- Number of patients registered with individual GP practices
- Number of Care Homes where patients are registered with the Care Home Support Team practices

Identify areas for improvement and discuss potential service development and improvement plan, via contracting meetings

Monitoring Requirements: The service will be monitored through regular meetings where performance reports will be reviewed. In year 1, monitoring meetings will be held on a monthly basis; this will be reviewed for year 2 and subsequent years thereafter.

Performance Reports: Performance and activity will be reported on a monthly basis. Fields to be included in monthly performance reports will, as a minimum provide information to measure key performance indicators. These key performance indicators may be added to as the service develops, but any changes will be mutually agreed with the service provider.

Quality Standards: Mandatory quality standards will be reported on a monthly basis and will form part of the monthly performance reports. Quality standards will include:

- Clinical outcomes
- Incident Reporting
- Compliments & Complaints
- Service User Satisfaction / Friends & Family feedback

The final detail of performance reports will be agreed with the service provider but will be based on the above.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE Quality Standard for End of Life Care QS13 (Quality Statement 1 – 16)¹

Applicable national standards (as stated or most recent publications)

- Department of Health (2009) Report. Living well with dementia. A national

¹ <https://www.nice.org.uk/guidance/qs13>

- dementia strategy
- Department of Health (2012) Prime Minister's Challenge on Dementia. Available at: <https://www.gov.uk/government/news/prime-minister-s-challenge-on-dementia>
- Department of Health (2013) Improving care for people with dementia Available at: <https://www.gov.uk/government/policies/improving-care-for-people-with-dementia>
- NICE Dementia: Supporting people with dementia and their carers in health and social care (CG42:2006). Currently under review
- The Social Care Institute for Excellence (SCIE)
- Guidelines on dementia (NICE clinical guideline 42),
- Depression in adults (NICE clinical guideline 90),
- Depression in adults with a chronic physical health problem (NICE clinical guideline 91),
- Delirium (NICE clinical guideline 103),
- Common mental health disorders (NICE clinical guideline 123)
- Social anxiety disorder (NICE clinical guideline 159) for more information.
- NICE quality standard 50, Mental wellbeing of older people in care homes

Mental Capacity Act

The Provider will be compliant with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards, within the Act. They will follow the guidance and use it to judge whether they are meeting their duties and responsibilities under the Act.

The provider should evidence that all staff are up to date with MCA/DOLs training to ensure they have a thorough understanding and awareness of capacity and consent issues and raise these with the care home as appropriate

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

- Royal College of General Practitioner (2012) Dementia: diagnosis and early intervention in primary care London
- Royal College of Psychiatrists (RCP), (2013) The financial case for reinvesting in mental health Available at: http://www.rcpsych.ac.uk/pdf/Bridging_the_gap_summary.pdf
- Memory Services National Accreditation Programme (MSNAP) Standards for Memory Services

<http://www.rcpsych.ac.uk/pdf/MSNAP%20standards%205th%20edition%20-%20web%20version.pdf>

4.3 Applicable local standards

Clinical Services

The Provider shall:

Provide services as defined by this Schedule to all residents, including residents registered as Temporary Residents

Not be required to provide Out of Hours Services (between the hours of 18.30 – 08.00)

Provide all Direct Enhanced Services appropriate to the provision of care required by the

health needs of the residents and directed by the Commissioner

Participate in the Quality and Outcomes Framework (QOF).

Implement the Gold Standards Framework and Electronic Palliative Care Co-ordination System (EPaCCS) for residents requiring end of life care

Participate in and support Health Promotion and Disease Prevention programmes as commissioned by Local Authority Public Health

Participate in Commissioners quality schemes as appropriate

End of Life Care

- Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life using EPaCCS
- Implement the Gold Standards Framework and Electronic Palliative Care Co-ordination System (EPaCCS) for residents requiring end of life care
- Do Not Attempt Cardiopulmonary Resuscitation Policy

Safeguarding

A culture must exist within the service that 'safeguarding is everybody's business. Providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported (as per Care Quality Commission, CQC registration requirements). Effective safeguarding arrangements should be in place to safeguard vulnerable children, young people and adults including, safe recruitment, effective training and supervision. Robust processes should be in place to assure the service themselves, regulators and commissioners that these arrangements are working. The service should work within the guidance of their organisation's Safeguarding Policy.

The Provider shall:

Provide the services to adults at risk who are registered with the practice in accordance with the standards contained in the National Service Framework for Older People (2001), and any protocols notified to the Provider by the Commissioner, as amended from time to time

Ensure that all Adults at Risk are assessed for any risk of abuse or neglect.

Ensure that medical and frontline staff, and anyone working on behalf of the Provider (including volunteers), are familiar with, and receive regular training in line with National guidance Safeguarding for Adults: Roles and competencies (to be published shortly) and Safeguarding Children and Young People: Roles and competences for health care staff, RCPCH (2014), and safeguarding policies/procedures as directed by the West and North Yorkshire and York Multi-Agency Safeguarding Adults Policies and Procedure as amended from time to time.

The Provider must ensure that they have safeguarding policies and procedures in place that comply with and reference the West and North Yorkshire and York Multi-Agency Safeguarding Adults Policies and Procedures, and staff receive training in relation to these policies and procedures.

The provider should have a GP safeguarding lead and systems in place for staff to seek advice as required from that person. The safeguarding lead will be trained to the appropriate level as defined by CCGs safeguarding policies and the National guidance Safeguarding for Adults: Roles and competencies (to be published shortly).The

safeguarding lead will regularly attend the GP safeguarding lead forum hosted by NK CCG. The safeguarding lead will seek advice from the designated safeguarding leads as required.

Participate in any relevant case conferences, work with, and accept support from the designated professional leads for safeguarding in the CCGs Area. This includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns

Safe recruitment policies will be in place which includes forbidding “compromise agreements” to prevent staff from resigning in order to avoid disciplinary proceedings in cases of abuse and neglect.

Ensure that all staff working with adults at risk have the appropriate level check as outlined by the Disclosure and Barring Service (DBS)

The Provider will be compliant with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards, within the Act. They will follow the guidance and use it to judge whether they are meeting their duties and responsibilities under the Act.

The provider should evidence annually that all staff are up to date with MCA/DOLs training to ensure they have a thorough understanding and awareness of capacity and consent issues and raise these with the care home as appropriate.

The provider will ensure that staff encourage care home residents to consider the anticipatory aspects of the MCA including Lasting Power of Attorney (LPA), Court Appointed Deputies and Advance Decisions to Refuse Treatment. Staff will be able to identify a valid and relevant LPA and act accordingly.

The provider will ensure that systems are in place to report any breaches of professionals code of conduct to the relevant professional body.

Medicines Optimisation

The Provider shall:

Prescribe the safest and most clinically and cost-effective medicines in accordance with national and local guidance including:

- i. NICE guidance and Department of Health directives relating to prescribing
- ii. Good Prescribing Practice as defined by BNF and adherence to local formulary (e.g. South West Yorkshire Area Prescribing Committee (SWYAPC)) for medicines. All organisations within the health economy should work together to achieve improvements in national QIPP and other locally agreed prescribing objectives to deliver safer and more cost-effective prescribing
- iii. Shared care protocols/guidelines agreed between the Commissioner and other secondary care NHS Providers
- iv. Ensure staff are working to Patient Group Directions (PGDs) as appropriate, e.g. to facilitate delivery of the national immunisation programme
- v. Meet with a member of the CCGs Medicines Optimisation team at least annually, or more frequently as agreed with the CCGs
- vi. Meet all requirements of the prescribing or medicines management/optimisation work plan agreed with the CCGs
- vii. Maintaining compliance with medicines safety alerts and provide evidence of compliance and provide evidence of learning and sharing locally from

- incidents. Also, provide timely information to the commissioner of untoward incidents involving medicines
- viii. Controlled Drug Incidents to be notified to the relevant Accountable Officer and the local CD Local Intelligence Network to ensure the safe management of CDs within the health economy
 - ix. Participation in national and local audits

Clinical Safety and Medical Emergencies

The Provider shall:

Ensure that all staff have and maintain basic life support certification with competence in defibrillation and ensure that all staff comply with the UK Resuscitation Council guidelines on Basic Life Support and the Use of Automated External Defibrillators

Ensure the availability of sufficient numbers of the Provider's staff with appropriate skill, training and competency and who are able and available to recognise, diagnose, treat and manage patients with urgent conditions at all times during opening hours

Possess the equipment and in-date emergency drugs including oxygen and IV fluids, Defibrillator to treat life-threatening conditions such as anaphylaxis, meningococcal disease, suspected myocardial infarction, status asthmaticus and status epilepticus

Pass all life threatening conditions to the ambulance service as soon as practicable by dialling 999 and requesting the ambulance service

Adhere to any national or local guidelines relating to clinical safety and medical emergencies in primary care as amended from time to time

Good Clinical Practice

The Provider shall ensure that:

Services are performed in accordance with the following requirements as amended from time to time:

1. Care Quality Commission Essential Standards in force during the term of this Contract
2. any relevant MHRA guidance, NICE guidance, technical standards, and alert notices are adhered to
3. the highest level of clinical standards that can be derived from the standards and regulations referred to in this paragraph 7.1 of Part A of Schedule 2
4. for GPs, the General Medical Council guidance on Good Medical Practice (2013 or most recently published)

Ensure that clinical meetings are convened for all clinicians working in within the Kirklees Care Home Support Team and registered GP relevant to the care, as a minimum of once each calendar month

Clinical Governance and Quality Assurance

The Provider will:

Show a commitment to achieve maximum possible points on the Quality and Outcomes Framework (QOF) and/or any future quality frameworks

Show a commitment and undertake best endeavours to achieve the highest banding

possible across the range of indicators on the NHS England Assurance Framework and/or any future quality scorecard as specified by the Commissioner by preparing and implementing suitable action plans until the standard is achieved

Show a commitment to work within local frameworks, particularly for locally commissioned services and public health standards to achieve the highest possible standard

Comply with any commissioner Quality Standards that may be introduced during the term of the contract, subject to the agreement of additional funding should it be reasonably required

Operate an effective, comprehensive, system of Clinical Governance with clear channels of accountability, supervision and reporting, and effective systems to reduce the risk of clinical system failure

Have medical leadership in place with a named clinical lead for all areas including Commissioner engagement

Nominate a person who will have responsibility for ensuring the effective operation of the system of Clinical Governance and who is accountable for any activity carried out on a patient

Continuously monitor and report on clinical performance as detailed in the Key Performance Indicators and service monitoring requirements

Use appropriate formal methods such as root cause analysis for serious incidents, near misses and complaints, and report via the correct channels, i.e. STEIS.

Have in place a system for collecting data on serious incidents, near misses and complaints in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements. Furthermore, the Provider shall have in place a system for adopting such changes into practice and processes

Operate robust auditing of clinical care against clinical standards and in line with CQC essential standards

Comply with the Commissioner's governance requirements and inspections and make available, on reasonable notice to the Commissioner, any and all Provider records (including permitting the Commissioner to take copies) relating to Provider clinical governance, to enable the Commissioner to audit and verify the clinical governance standards of the Provider

Where appropriate, fully implement any recommendations following Commissioner clinical governance inspections within three (3) months of notification by the Commissioner of the recommendations, including the development and submission of improvement plans as required by the commissioner

Participate in all Commissioner quality and clinical governance initiatives

Risk Management

The Provider shall:

Operate mechanisms for assessing & managing clinical and general business risk including the maintenance of a suitable risk register that is reviewed, as a minimum by the Provider on a monthly basis

Prepare disaster recovery, contingency and business continuity plans that should be

available for inspection by the Commissioner at any time ensuring named medical cover for agreed contract times

Keep the Commissioner fully informed about any significant risks that have been identified that could impact on the performance of the contract

Notify the Commissioner of the person responsible for risk management within the Provider's organisation

Equity of Access

The Commissioner acknowledges that to improve equity of access for black and minority ethnic (BME) communities, it is important to collect information on ethnicity and first language due to the need to take into account culture, religion and language in providing appropriate care packages and the need to demonstrate non-discrimination and equality of access to service provision. The Provider shall therefore be required to record the ethnic origin and first language of all registered patients.

The Provider will have systems and policies in place to ensure that it is responsive to the individual needs of its service users and will demonstrate it makes all reasonable adjustments to ensure that its services are accessible, appropriate and flexible, whether this is in terms of the location of the service or the provision of service.

The Provider will consider the specific needs of protected groups in relation to the service provided, making specific arrangements where necessary, such as interpreting, longer appointment times or home visits.

All protected characteristics will be considered and adjustments made, but particular attention will be paid to disabled people, including those with learning disabilities and to people who may have additional communication requirements. Providers will comply with the NHS Accessible Information Standard.

The provider will produce accessible materials and signposting information to publicise and promote the services as required. The information will include a clear description of how the service operates, how it fits with other services, what to expect from the service (in terms of processes and outcomes) and how to register a compliment/complaint. The Provider will ensure that information about the service is provided to all individuals using the service and potential service users and their carers/family, in appropriately accessible formats. This information should reflect the diversity of the local community.

The Provider shall:

Not discriminate between residents on the grounds of age, sex, sexual orientation, ethnicity, disability, or any other non-medical characteristics

The service Provider must implement Royal National Institute for the Blind, Royal National Institute for the Deaf guidance and other relevant guidance to ensure residents who have disabilities and/or communication difficulties, are able to access the services. This includes ensuring arrangements are in place to enable staff to communicate fully with people that have a hearing impairment and may involve the Provider ensuring there is the correct assisted hearing system(s) available and in working order, (e.g. loop system) or a BSL interpreter available if required, or having a dedicated telephone number for text phone users who have hearing difficulties to enable them to access the Services. Frontline staff should undertake Deaf Awareness training and services should note that Reasonable Adjustments only include lip reading or written information if that is the method of communication that the patient requests

For people that have sight loss, make information available in a format suitable to them e.g. large print, Braille, audio tape or audio CD. For people that have dual sensory loss (sight and hearing impairments), an interpreter or communicator guide should be made available

to enable effective communication to occur between staff and patient

Utilise available professional translation services:

1. as required for all non-English speaking residents during all consultations
2. to provide appropriate translations of materials describing procedures and clinical prognosis, where it is normal procedure to provide such materials in English, for the languages most commonly spoken by residents who are likely to use the Services

Take reasonable steps to proactively deliver health promotion and disease prevention activities to all care home residents including but not be limited to the following patient groups:

1. those who do not understand written or spoken English
2. those who have any hearing, sight or dual sensory impairment, or have other disabilities
3. those who have mental illnesses

The Provider will have systems/procedures/policies in place to equality monitor referrals and service users, and will report this as required to the commissioner. The provider will evidence actions undertaken to address any preventable inequalities of access, experience or outcomes, where these become apparent. The Provider must ensure that they are, where appropriate, providing services to the local community equitably.

The Provider will assess the impact of its services and work with service users and other stakeholders to understand whether there are any barriers to improved access, experience or outcomes. Where these are identified, reasonable steps should be taken to minimise the impact of the barriers.

The Provider must carry out an annual audit of its compliance with these obligations and must demonstrate at review meetings the extent to which service improvements have been made as a result.

Health Promotion and Disease Prevention

The Provider shall:

Provide services focusing on health promotion and disease prevention and work with the Commissioner, CCGs, Local Authority, other local GP practices and other health Providers on initiatives to promote health and prevent disease within the Commissioner's area

Ensure it has effective strategies for health promotion and disease prevention in place these shall include, but not be limited to:

- smoking
- alcohol
- obesity
- lack of exercise (if appropriate)
- dietary habits
- sexual health

Identify and proactively screen and manage residents at risk of developing long term conditions, mental health problems, cancers and sexually transmitted infections

Provide information about, and access to, self-management programmes for residents with

long term conditions where appropriate

Identify local care pathways for residents with long term conditions to reduce inappropriate and unnecessary hospital admissions

Provide information and advice to residents on self-monitoring for long-term conditions

Use computer-based disease management templates

Implement appropriate DH, NICE, MHRA and any other relevant guidelines (as amended from time to time) that apply to the provision of primary medical care services for residents

For the purposes of this paragraph 10, 'Long Term Conditions' shall be deemed to be those conditions that cannot at present be cured, but which can be controlled by medication and other therapies

Patient Dignity and Respect

The Provider shall:

Ensure that the provision of the Services protect and preserve patient dignity, privacy and confidentiality.

Allow patients to have their personal clinical details discussed with them by a person of the same gender, where required by the patient.

Provide a chaperone for intimate examinations to preserve patient dignity, and respect cultural preferences.

Ensure that the Provider's staff and anyone acting on behalf of the Provider behaves professionally and with discretion towards all residents, carers and visitors at all times

Informed Consent

The Provider shall comply with NHS requirements in relation to obtaining informed consent from each patient prior to commencing treatment including the following as amended from time to time:

- Department of Health Good Practice in Consent Implementation Guide: Consent to Examination or Treatment 2001 (or most updated version)
- Health Service Circular HSC 2001/023
- Consent: Patient and Doctors making decision together: RCGP 2008 (or most updated version)
- The Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007) and accompanying Codes of Practice
- Guidance on covert medication

Patient Records

The Provider shall at its own cost retain and maintain all the clinical records in accordance with:

Good Practice Guidelines:

<https://digital.nhs.uk/information-governance-alliance>

The provider will be compliant with all GDPR Regulations

The Provider shall at its own cost retain and maintain all the paper based clinical records in chronological order and in a form that is capable of audit. The Provider is responsible for complying with NHS Digital requirements in relation to 'Paper-free at the Point of Care' agenda.

Patient records should be retained in line with the records management code of practice for health and social care

<https://digital.nhs.uk/article/1202/Records-Management-Code-of-Practice-for-Health-and-Social-Care-2016>

Provider Records

The Provider shall during the term of this Contract and for a period of ten (10) years thereafter, maintain at its own cost such records relating to the provision of the Services, the calculation of the Charges and/or the performance by the Provider of its obligations under this Contract as the Commissioner may reasonably require in any form (the 'Records'), including information relating to:

- Contract management reporting
- National/data set reporting

The Provider shall, subject always to the provisions of relevant legislation and Directions:

On request produce the Records for inspection by the Commissioner or, on receipt of reasonable notice, allow or procure for the Commissioner and/or its authorised representatives access to any premises where any Records are stored for the purposes of inspecting and/or taking copies of and extracts from Records free of charge and for the purposes of carrying out an audit of the Provider's compliance with this Contract, including all activities of the Provider, the Charges and the performance, and the security and integrity of the Provider in providing the Services under this Contract

Preserve the integrity of the Records in the possession or control of the Provider and Provider Staff and all data which is used in, or generated as a result of, providing the Services

Prevent any corruption or loss of the Records, including keeping a back-up copy

Provide any assistance reasonably requested by the Commissioner in order to interpret or understand any Records

The Provider shall ensure that during any Records inspection the Commissioner and/or its authorised representatives receive all reasonable assistance and access to all relevant Provider staff, premises, systems, data and other information and records relating to this Contract (whether manual or electronic)

Infection Control and Prevention

The Provider shall have in place arrangements that meet the standards outlined in the NICE guidelines - *Health care-associated infections: prevention and control in primary and community care (March 2012 or most recent)*, It offers evidence-based advice on the prevention and control of healthcare-associated infections in primary and community care. New and updated recommendations address areas in which clinical practice for preventing healthcare-associated infections in primary and community care has changed, where the risk of healthcare-associated infections is greatest, and where the evidence has changed.

To comply with NHS England Standard Operating Procedure Infection Prevention & Control Audit requirements and the The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2016):

Use only disposable medical devices

Make arrangements for the ordering, recording, handling, safe keeping, safe administration

and disposal of medicines used in relation to the Services

Make arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff (including any clinical practitioners which the Provider has asked to carry out clinical activity)

Follow appropriate guidelines to the management of hospital acquired infections

Complaints procedure

The Provider will:

Produce and publicise in the service/practice leaflet and on the website, a complaints procedure that is consistent with the latest version NHS Complaints Policy. The complaints procedure must be easy to understand, accessible and available to the homes to residents and provide for a prompt response

Respond to complaints with acknowledgement of receipt within 3 working days, and respond fully to complaint within a maximum of 28 days, or mutually agreed with the complainant depending on the severity. Difference between acknowledgement (3 working days) and response. Timescales should be mutually agreed with the complainant and are dependent on severity.

If a case has passed the 40 working day target (or the timescale agreed with the complainant if different), the complainant (and advocate if relevant) should receive an update every 10 working days thereafter the target has been surpassed. This could be by telephone, email or letter but the format should be agreed with the complainant

www.england.nhs.uk/wp-content/uploads/2016/07/nhse-complaints-policy-june-2017.pdf

Ensure all complaints are monitored, audited and appropriate action taken when required

Take reasonable steps to ensure that residents are aware of:

1. The complaints procedure
2. The role of the NHS England and other bodies in relation to complaints about services under the Contract
3. The right to assistance with any complaint from independent advocacy services provided under section 19A of the Complaints Act

Take reasonable steps to ensure that the complaints procedure is accessible to all residents; being aware of language, and communication support needs

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

With regard to the Quality and Outcomes Framework (QOF) as defined in the GMS Contract Regulations and/or any future National Quality Framework, the Provider shall:

Participate in the QOF Scheme each year pertinent to this client group

Work towards gaining the maximum possible QOF points for each Contract Year appropriate to this client group

Take all reasonable steps to minimise exception reporting and improve prevalence rates on practice registers

To participate in any locally agreed QOF scheme pertinent to this client group

The Provider shall encourage discussion with residents, their families, carers and staff, and actively seek their views on a range of topics, including, but not limited to the following subject areas:

1. Access, including opening hours, telephone access, availability of reviews
2. Clinical services
3. Experience in using the services
4. How patient feedback is being used to improve clinical standards
5. How patient feedback is being used to improve patient experience

The Provider shall be required to fully cooperate and assist the Commissioner in measuring patient satisfaction on an on-going basis. The method for measuring patient satisfaction may include touch screen, written surveys, interviews or other appropriate mechanisms. The methods must include, but is not limited to:

1. An annual locally-administered survey of residents
2. Compliance with the requirements to implement the NHS GP Friends and Family Test
3. Patient & Carer's Reference Group
4. Compliance with locally commissioned services
5. The NHS England national annual GP Patient Survey
6. Five yearly individual clinician patient survey responses to be collected using standard questionnaires that comply with GMC guidance and as set out within the revalidation process

Telemedicine

Providers will be expected to demonstrate:

How the following are managed;

- i. The supply/purchasing of equipment
- ii. The licensing of equipment
- iii. The maintenance of the equipment
- iv. The replacement of the equipment
- v. The Business continuity plans and disaster recovery processes should equipment fail
- vi. Deliver using a project management approach for installation and configuration of the equipment

The Providers will be expected to include:

- i. Secure connection to N3 services if required
- ii. 4G services
- iii. Monthly reporting activity of service usage against an agreed minimum data set.

Operational detail including:

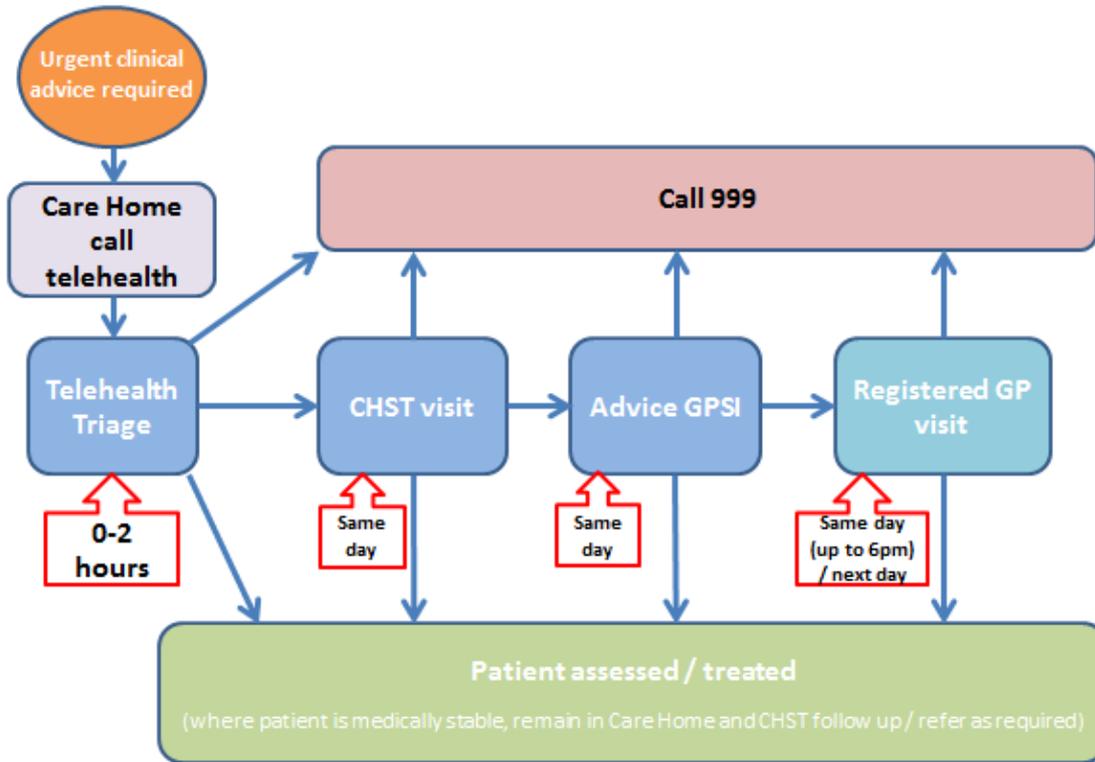
- i. How care home staff will be supported to understand and use the telehealth units
- ii. How care home managers will be encouraged / supported to use telehealth in their care home
- iii. What peripherals will be included and excluded

5.2 Applicable CQUIN goals (See Schedule 4D)
6. Location of Provider Premises
The Provider's Premises are located at:
7. Individual Service User Placement
8. Glossary
The following words shall have those meanings as described below for the purposes of this Schedule 2. 'Residents' means all those persons that are provided a service under this Agreement. 'Frontline Staff' means any staff or other persons engaged by the Provider that have direct contact with residents. 'BNF' means British National Formulary. Routine Work means proactive/anticipatory/non urgent work Reactive Work means unplanned acute clinical work

APPENDIX A - Pathways for 0-2 hour response

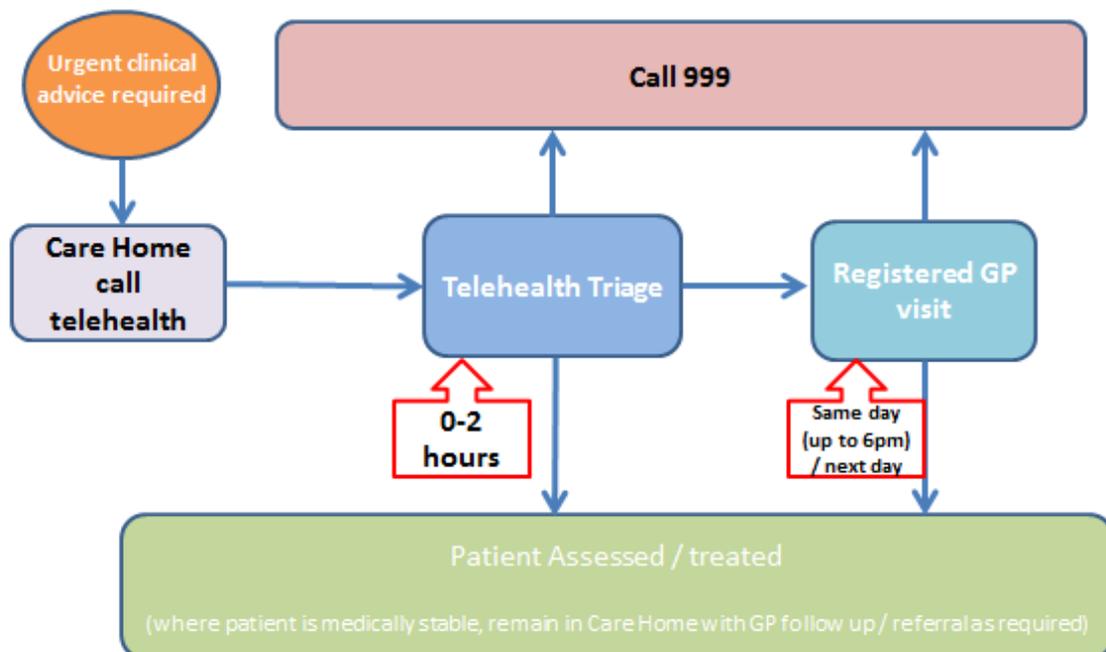
In hours 0-2 hour response

(patients covered by MoU or registered with Care Home Support Team)



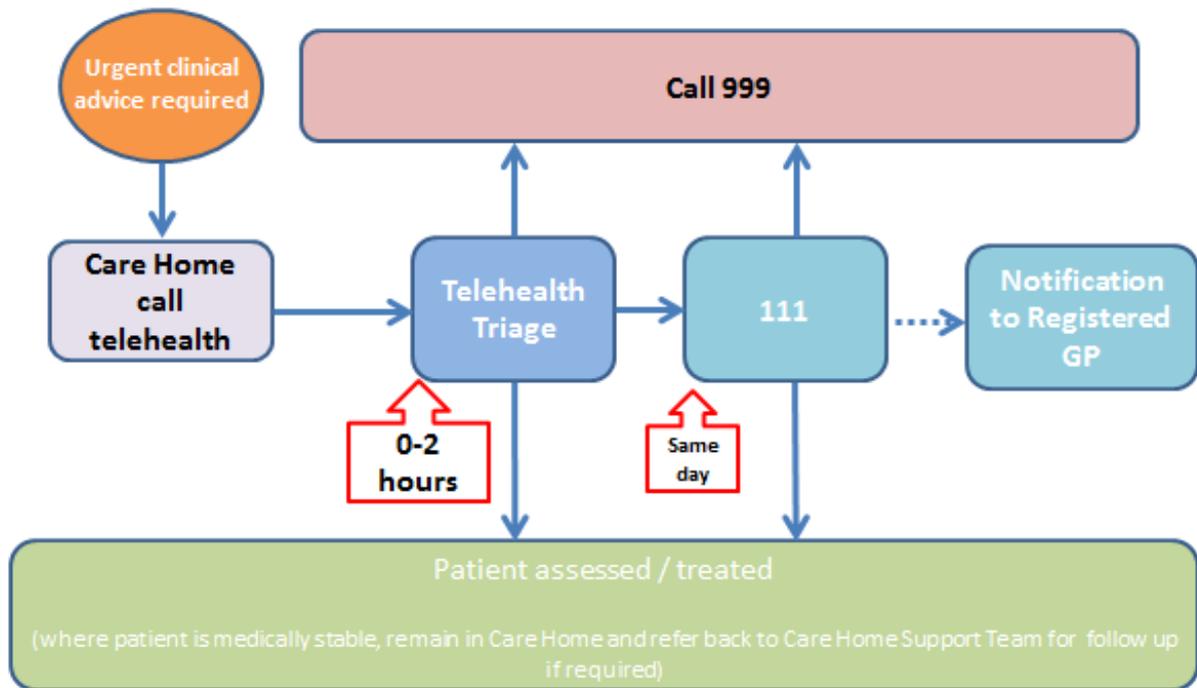
In hours 0-2 hour response

(patients **NOT** covered by MoU or registered with Care Home Support Team)



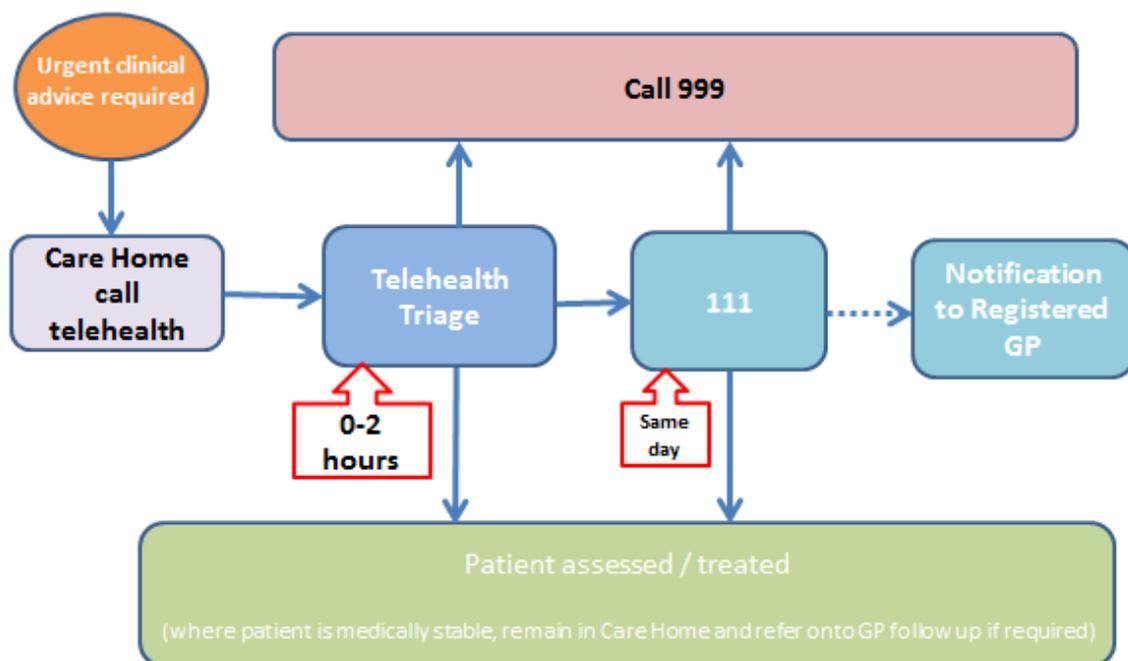
Out of hours 0-2 hour response

(patients covered by MoU or registered with Care Home Support Team)



Out of hours 0-2 hour response

(patients **NOT** covered by MoU or registered with Care Home Support Team)



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