Service Specification No.	
Service	**Continuing Care: Highly Complex Healthcare**
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 General Overview

This specification is for Highly Complex Continuing Healthcare services to support adults (aged 18 and over) assessed as eligible for Continuing Healthcare (CHC) and registered with a Leeds GP, or resident within the boundaries of the 3 Leeds Clinical Commissioning Groups. The service is provided by multiple providers all offering complex healthcare services to service users in Leeds.

The purpose of the Highly Complex Continuing Healthcare service is to enable CHC eligible service users to remain in their own home, living as safely and independently as possible. For the purpose of this specification, highly complex continuing healthcare will involve the provision of some or all of the following:

- 24 hour care in service users own home – (see section 3.2 for further detail)
- Personal Care
- Health Care
- Maintenance of independent living skills
- Domestic tasks including shopping, laundry and meal preparation
- Carer support, including night sitting and respite care

1.2 Evidence Base

The principles that underpin this specification have been developed from policy and guidance including:

- Essential Standards of Quality and Safety (2010)
- Domiciliary Care National Minimum Standards, Regulations (2003)
- National Framework for NHS Continuing Health Care and NHS Funded Nursing Care (revised 2012)
- Gold standards Framework, Leeds care pathway for palliative care
- Skills for Care – Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England (2013)
- Skills for Care - National Minimum Training Standards for Healthcare Support Workers and Adult Social Care Workers in England (2013)
- NMC – The Code; Professional Standards of Practice and Behaviour for nurses and midwives (2015)
- NMC – Standards for medicines management
- Royal Pharmaceutical Society of Great Britain – The Handling of Medicines in Social

Care, 2007

- NICE Guidance NG67 Managing medicines for adults receiving social care in the community (NICE guideline published: 30 March 2017 nice.org.uk/guidance/ng67 © NICE)
- Skills for Health –Core Skills Training Framework for end of life
- Skills for Care – National End of Life Care Qualifications in Social Care – 2013 Department of health – End of Life Care Strategy 2008

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 Locally defined outcomes

The expected outcomes for the service are as follows:

- To achieve and maintain the service user's optimum health status
- To enable individuals to safely remain in their own environment for as long as possible
- To improve and/or maintain independence
- To reduce hospital admissions
- To reduce the risk of avoidable healthcare associated infections
- To reduce stress in the Individual and/or carers and enable them to carry out their caring role and/or family role for as long as they are able and willing to do so
- To improve individual satisfaction levels incrementally

3. Scope

3.1 Aims and objectives of the Highly Complex Continuing Healthcare Service

- Ensure that care is delivered as identified within the Provider's Care Plan, through a range of interventions tailored to meet individual needs
- To enhance the quality of life of the service user
- To support service users to live as healthily and independently as possible irrespective if their condition

- Ensure Service Users and carers experience person centred outcome focused care in which the service user (and/or their designated representative) are involved and satisfied with the plan of care
- Provide appropriate levels of skilled and competent care staff trained in a range of care interventions to meet the wide range of physical, mental, emotional, cognitive and cultural care needs of the service user
- Ensure risks are identified and managed appropriately, in order to protect the safety of the service user and care workers
- Contribute to a multi-disciplinary approach, ensuring effective communication with all Health and Social Care professionals involved in the care of the service user
- Provide person centred information and support for service users, families and carers, pre and post bereavement

3.2 Service Description

Highly Complex Continuing Healthcare service users typically require 24 hour care in their own home. The care can normally be provided by Health Care Assistants who develop specific skills to meet individual needs, are working to care plans developed by a qualified registered nurse and are closely supervised by a trained nurse. Very exceptionally a trained nurse may be required to deliver some of the care required.

Examples of highly complex clinical needs include but are not limited to:

- Mechanical ventilation, suction or use of cough assist
- 24 hour invasive and non-invasive ventilation
- Epilepsy
- Multiple disabilities
- Tetraplegia and complex spinal injuries
- Final stages of some degenerative conditions
- Patients requiring advanced competencies and/or case management by a qualified nurse
- Other intensive needs which may require continuous 24 hour care

Highly Complex Healthcare Services will be commissioned by Case Managers (acting on behalf of the Commissioner) through a Patient Service Request Form (PSRF) and Care Plan, which details the specific services required for an individual service user.

3.3 Population covered

Only service users registered with a Leeds GP, or resident within the boundaries of the 3 Leeds Clinical Commissioning Groups **and** approved by the Leeds Continuing Care Service can receive services under this agreement. A person who is not eligible for continuing health care in Leeds or whose GP is from a neighbouring area is therefore excluded from this service.

3.3.1 Exclusion Criteria

The Highly Complex Continuing Healthcare Service excludes packages of care for Continuing care eligible service users with non-complex needs. Services for these service

users will be commissioned outside of this agreement.

3.4 Interdependence with other services/providers

The provider will work in partnership with commissioners and all other stakeholders contributing to the care pathway, including:

- Leeds Continuing Care Service
- Health Case Management
- Continuing Care End of Life Service
- General Practitioners
- Leeds Community Health Services – particularly Community Nursing, Community Nursing Nights, Nights Roaming and the Palliative Care Service
- Adult Social Care
- Leeds Community Equipment Service
- Other Domiciliary Care Providers
- Acute Service Providers

Service interdependencies will vary depending on the individual needs of the service user as set out in the care plan or individual service agreement. The provider will be expected to work in partnership with all other services or providers involved in caring for the service user.

The Commissioner works in partnership with Leeds City Council and the Care Quality Commission, and may share service related information with these organisations or other bodies to support monitoring and quality assurance processes.

3.5 Service delivery

3.5.1 Referral Route

In accordance with the National Framework for Continuing Care (2012), assessment for eligibility is made by a multi-disciplinary team involved with the person's care using the National Decision Support Tool (2012). Assessments take account of the individual's views and the views of their families or advocates as well as those of the health and social care professionals involved in the case.

Highly Complex Continuing Healthcare services are commissioned by the service user's Case Manager or the Leeds Continuing Care Service. New referrals to providers will be made using the established process on the following basis:

1. Size of the total care package required
2. Required competency level - complexity
3. Service User preference: the views of Service Users and/or their Carer(s) will be considered in the choice of an appropriate service provider.
4. The Provider's available capacity to meet the required start date for the care package and competencies required for the package
5. Best Value – determined by the Provider's contract price(s)

3.5.2 Care Commissioning Process

At the point of referral, the Care Coordination Team will supply the Provider with a high level care plan and background information for the service user, and a Patient Service Request Form (PSRF) for the service user. For the purposes of this specification these documents

will be referred to as the Support Plan.

Wherever practicable, the Care Coordination Team will give the Provider a minimum of 24 hours verbal notice of the need to provide services to an individual service user. This will be followed by confirmation in writing from the Commissioner (or their representative) within 3 working days. Wherever practicable the Support Plan for the service user will be shared with the Provider in advance of the proposed commencement date for the care package.

3.5.3 Care planning

The Provider will be responsible for developing and maintaining the Care Plan for each service user. The Care Plan will set out in detail the action that will be taken by the Provider to meet the service user's needs, including any specialist needs and communication requirements and identify the service user's desired outcomes for the service.

The Care Plan shall be written with the involvement of the Service User, and/or their representative, and any other professional as appropriate. The Care plan will take into account the service user's preferences in relation to the way in which the care is provided and their own chosen lifestyle – as long as it conforms to legal requirements and does not compromise the Provider's obligations.

The Care Plan and any associated assessments will be reviewed at least monthly to ensure that they are appropriate to meet the ongoing needs of the service user.

The Provider is required to agree call times with the Service User to meet the needs of individual Service Users and their Carer. The Provider will agree specific times for visits with the Service User and/or their Carer prior to the first visit.

The Provider will ensure that Care Plans and comprehensive clinical and risk assessments and effective risk management systems are in place to ensure that care can be delivered safely at the first visit and throughout the duration of the care package. Safeguarding training, policies and procedures are imperative.

An early assessment of an individual's needs and wishes as they approach the end of life is vital to establish their preferences and choices and identify any areas of unmet need. It is important to explore the physical, social, spiritual, cultural and where appropriate environmental needs/wishes of each individual.

3.5.4 Service Delivery

The Provider is responsible for the ongoing assessment and management of risk associated with the service user. The Provider is required to monitor individual service users on an ongoing basis and report any significant changes to appropriate Case Management Team. Such changes may include:

- Deterioration which affects the care needs of the service user (e.g. additional support required)
- Indications that another service may be required, i.e. respite, adaptations or equipment, or onward referral to specialist service via GP.
- Serious concerns about the Carer or other persons directly involved with the service user, which are affecting the care or safety of the service user
- Significant progress requiring a decrease in service or alternative tasks required
- The service user's or carer's wishes to terminate the service
- Service user progressing to terminal phase – which should be communicated immediately to the responsible Community Nursing Team

The service will commence on the date and time as agreed in the individual service agreement. Each service user shall receive visits according to the needs and objectives identified on the service user's Care Plan.

The Provider must ensure that all relevant Provider staff members are given an appropriate and adequate briefing regarding the service user's needs and specific details of the way in which they are to be met, prior to commencing their work; sufficient information should be provided to care staff to allow them to deliver care safely at the first visit and throughout the duration of the care package.

The service time for each visit starts only upon the commencement of the service to the Service User unless specified in the Support Plan. Separate payment will not be made for any costs associated with travelling to and from the service user's home.

All documentation of the care arrangements (Provider's own assessments & comprehensive care plans) should be in place within two days of the start of the care package.

The service will be provided as per the Care Plan and will be continuous without exception.

The Provider must have in place contingency arrangements to ensure adequate, available cover in the case of any planned or unplanned increases in workload, staff absences, or medical emergencies. It is the responsibility of the Provider to make appropriate replacement arrangements if a care worker is unable to deliver the service as scheduled.

In exceptional circumstances if the Provider is unable to provide a service, then the Provider should contact the Care Coordination Team to seek approval and make alternative arrangements. The service user should not be left without a service unless this is explicitly agreed between the service user (or their designated representative), the Commissioner and the Provider.

Provider staff are visitors to the service user's home and as such can be refused entry or be asked to leave by the service user at any time (except for service users who are under guardianship). Such requests must be complied with and where a service user refuses entry or rejects a Care Worker, the Provider is required to investigate the reason and where appropriate provide an alternative Care Worker. Where an alternative Care Worker is not accepted and all reasonable steps are taken, the responsible Case Management Team must be notified immediately for remedial action to be identified.

In the event that a service user cancels or refuses a visit, the Provider must record the cancellation and relevant details, and report this to the Commissioner as part of consolidated weekly reporting via Leeds Care Finder.

The Provider will work with and support any other service identified within the Support Plan or Care plan. Domiciliary Care Providers must ensure that they have contact details of all personnel or other services involved with the care package on file and available within the service user's home, to include details of the responsible Case Manager or Case Management Team.

The Provider is required to maintain appropriate documentation in the service user's home to monitor service delivery. Provider staff must record any major observation or changes which might be of significance to other professionals and communicate with them where appropriate. This may involve directly contacting other services and contributing to the documentation/records of other Services (e.g. Community Nursing) as well as the Provider's own records.

The Provider will monitor and evaluate the attainment of the service user's outcomes and report changes, including any significant improvement and/or deterioration in the service user's circumstances or needs to the Commissioner. The Provider should also be able to give feedback when requested by the Commissioner in relation to the achievement of

specified outcomes as identified by the service user.

In the event of a significant deterioration in the service user's condition or other immediate health need, the Provider is expected to immediately notify the Case Manager, General Practitioner, Community Nursing Service or Emergency Services as appropriate to the situation and recognising the service user's preferences (e.g. DNAR status).

3.6 Response time and prioritisation

Providers must offer a contact point to receive and process new referrals 7 days a week.

The Provider will actively support the Commissioner and Case Managers in prioritising and facilitating early discharge from secondary care. The Provider is expected to attend case conferences or care planning meetings as reasonably requested to support hospital discharges.

On occasion Domiciliary Care Services are required at short notice (i.e. care required within 3 hours of referral) to respond to an emergency situation or assist the service user to stay in their home. The Provider may be therefore be requested to respond rapidly to new referrals in exceptional circumstances. Normal referral timescales (as outlined in 3.5 above) will not apply, however it is expected that Case Managers will supply sufficient information at the time of referral to allow the Provider to safely meet the needs the Service User concerned.

Providers of emergency support will need to work in partnership with carers, Case Managers and other providers as necessary to ensure that emergency support is safely delivered. Where a care package is commenced at short notice, all care arrangements including support plan, and provider's care plans/assessments should be in place within 2 working days following service commencement.

3.7 Review Processes

3.7.1 Eligibility Review

An individual's needs will be reviewed by the Leeds Continuing Care Service after 3 months and then at least annually to ensure that the services provided are meeting the identified needs and that the service users needs have not changed, increased or reduced. These reviews will include a review of continuing health care eligibility status.

The Provider will contribute to reviews of the care/support provided by providing information and full participation in the review if requested. These reviews will be coordinated by the Case Manager or Care Coordination Team. The information required will include:

- Information about progress achieved towards individual agreed outcomes will need to be provided for the service user's individual care plan review.
- Progress in achieving the outcomes identified by each individual should be measured using a format agreed between the commissioner, providers and service users.
- Variation to types of support given as progress is made towards achieving individual outcomes.

3.7.2 Care Package changes

In the event of a significant change in the service user's needs the Provider is expected to immediately notify the relevant Case Manager and/or the General Practitioner where there is an immediate health need.

The Provider, Commissioner, or service user (and/or their designated representative) may at any time request a meeting for the purposes of reviewing a care plan or any part of the Services under this agreement. Such a meeting shall be held as soon as is reasonably

possible after the request for a meeting has been made.

The Commissioner shall have the final decision as to whether a care plan or the commissioned level of service requires amending. An amended care plan will be issued by the Commissioner and shall be signed by all the relevant parties.

Following a review if the Commissioner decides in its sole discretion that a service user's needs have not been met and/or the stated outcomes have not been delivered then the Commissioner and Provider shall work together to agree a remedial plan to ensure that the needs of the service user will be met.

Any significant changes to the approved Care Plan must be agreed with the Case Manager and any other appropriate health and social care professional responsible for the person receiving services.

A new ISA will be required for any permanent service changes.

The price for additional care hours will not be payable without the approval of the Leeds Continuing Care Service.

3.7.3 Emergency or Additional Temporary Care

For service users which are already receiving a service from the Provider, additional services may be required to deal with an emergency or a significant temporary increase in care needs, in these circumstances:

- All additional temporary or emergency care shall be recorded and emailed for approval to the Care Coordination Team within 2 working days. The email will contain the following information;
    - Patient ID
    - Reason for change
    - Hours provided
- All variations from the care plan should be recorded, including the reasons for the need to increase the service. These records must be made available for inspection or audit if requested by the Case Manager or Leeds Continuing Care Service.
- The Provider must contact the Case Manager for approval of any significant increase to the level of care detailed in the care plan and to request an urgent review.
- The Price for additional care hours will not be payable without the approval of the Care Coordination Team.

3.8 Discharge Criteria & Processes

The service must not be discontinued without either a Continuing Care Review or a service review where a Case Manager should be present. In exceptional circumstances, i.e. where there is a potential danger to staff or identified risk of abuse or harm to Care Workers, this must be notified to the responsible Case Management Team immediately for remedial action to be taken.

If, as a result of a review, continuing care or fast track eligibility is rescinded, but ongoing care input is required to support continuity of care, the care package may be transferred to Leeds Adult Social Care, provided that the person is eligible under the Fair Access to Care Services (FACS) eligibility criteria. Such a transfer may result in the care package being reviewed or terminated by Leeds Adult Social Care. The Provider will be given no less than 7 days written notice of a proposed transfer of a care package to Leeds Adult Social Care.

The Commissioner shall have the right to terminate any Care Plan or Individual Service Agreement by serving no less than 7 days' written notice to the Provider.

The Commissioner shall have the right to cancel an individual service agreement forthwith by serving notice on the Provider where the Commissioner considers that the Provider is placing or has placed the service user's health, safety, or welfare at risk.

The Provider will be required to give at least 30 days' written notice if they wish to suspend or terminate an individual care package. In exceptional cases the Provider may be required to continue providing a service beyond the 30 day notice period until such time as a suitable replacement and handover of care responsibilities can be arranged.

Where a service user is admitted to hospital for a continuous period greater than 24 hours, the service will be discontinued and the price will only payable up to the date of admission. The service user will be assessed at discharge and as appropriate the Case Manager will arrange for either the recommencement of the service or commission a new package of care from an alternative provider.

The Provider shall inform the Commissioner immediately in writing upon the death of a service user. In the event of the death of a service user the price for the individual care package shall only be payable up to date of death.

3.9 Response to Emergency Situations

- The Provider must have written procedures for dealing with emergency situations which should include an emergency out of hours on call system
- When any staff member, during the course of their duties, identifies an emergency situation, sufficient and appropriate action must be taken to ensure the immediate health and comfort of the service user
- Where the staff member cannot deal with the emergency, the Provider must ensure that a senior manager is available immediately to deal with the problem
- In the event of an emergency, the appropriate emergency service must be notified immediately and the relevant documentation completed
- Any circumstance where the service user appears to be in need of medical attention but refuses to seek medical help

4. Applicable Service Standards

4.1 Applicable national standards

The Provider will comply with the Care Quality Commission's *Registration and Fundamental Standards 2015*. The provider must be appropriately registered with the Care Quality Commission with a registered location in Leeds.

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per guidance set out in section 1.2.

4.3 Applicable local standards

4.3.1 General Standards

The Provider must ensure that it has written procedures/protocols in place to ensure good practice and that care workers are fully aware of the written protocols and procedures and how these affect the service user's care.

The Provider shall take into account the cultural and diverse needs of the Individual and their families and shall be mindful of potentially sensitive domestic circumstances.

4.3.2 Timeliness of visits

The Service Provider is expected to deliver a service at the time agreed with the Service User. It is however recognised that there will be exceptional circumstances leading to some late arrivals. If any care worker is expected to be more than 20 minutes later than the appointed time, the service user, and all other service users to be visited that day and likely to be affected, must be notified of the anticipated time of arrival. Such eventualities must be recorded and available for quality evaluation monitoring at the request of the Commissioner.

4.3.3 Care planning

The provider is expected to review all care plans at least monthly, or sooner upon a change in the service user's condition, to ensure that care plans are appropriate to meet the current needs of the service user. Care plan reviews should be clearly documented, including the date and person carrying out the review, and be auditable by the Provider and Commissioner.

4.3.4 Information for Service Users

The Provider will supply information to patients and/or their representatives in a range of formats and languages appropriate to the local population. As a minimum this information should include:

- Service User Guide which outlines the service and includes relevant contact details for the Provider
- Safeguarding Awareness
- Information on how to access the Patient Advice and Liaison Service (PALS)

4.3.5 Workforce & Recruitment

The Provider must have in place a detailed staffing plan that describes the staffing arrangements that will enable the delivery of the services for the duration of the agreement.

The Provider must ensure that all staff have the necessary training, qualification, experience, competence and communication skills to undertake their roles. Staff may require specific individual training and competencies where a service user's needs require specific competencies. A registered nurse should ensure structured approaches and interventions to support service users who have highly complex health needs.

The competency standard for all care workers delivering the service should be as follows:

- Care Workers - NVQ2 or NVQ3 in Health and Social Care or NVQ 2 or 3 in Healthcare, or Level 2 or Level 3 Diploma in Health and Social Care under the new Qualification Credit Framework.

- All care staff should have specific End of Life training as part of the induction process and prior to seeing any service users. As a minimum the provider will ensure that all care staff have achieved, or are actively working towards completion of the EOL 201 module of the Level 2 QCF (or an equivalent qualification).

- Providers of Highly Complex Continuing Healthcare services must have a Registered Nurse with a current registration working within the local branch. The Registered Nurse should have an appropriate level of training and experience to enable them to provide clinical leadership, clinical direction, clinical governance for the service, including clinical care planning and supervision of care workers.

- Staff should be trained in the specific care needs of the service user, examples of this (not exhaustive) include ventilation, cough assists, suction, tracheostomy management, medicines management, seizure assessment/management, nebulizer therapy, monitoring symptoms that may need palliative care/nursing intervention, blood sugars, oxygen therapy and feeding service users with an aspiration risk.

All staff will be regularly updated with respect to statutory and mandatory training and a system will be put in place for monitoring ongoing compliance. The Provider will be required to demonstrate its on-going training provision and knowledge/competencies of its staff.

The Provider will ensure that all staff, contractors and volunteers undertake safeguarding awareness training on induction, including information about how to report concerns within the service or directly into the multiagency procedures. The Provider will ensure that all staff receive regular refresher training on safeguarding at a level and frequency appropriate to their role and responsibility.

All Provider care workers will have formal supervisions at least quarterly. All supervisions will be documented and available for audit. All staff will have an annual appraisal/review and personal development planning. The provider will have a Supervision Policy and monitoring processes in place to ensure compliance.

The Provider must have a recruitment and retention policy that supports the delivery of the services and enables them to attract and retain a high quality, competent workforce in adequate numbers for the duration of the agreement.

The Provider will have its own policies and procedures in relation to the recruitment of staff including undertaking the necessary security measures. The Provider must implement a comprehensive induction programme for all Staff that will support their workforce strategy and the delivery of the services.

4.4 Medicines Management

To ensure that medicines are managed safely, securely and appropriately, the Provider will have policies and procedures in place to meet the requirements of the CQC *Registration and Fundamental Standards 2015*.

The provider will follow NICE Guidance NG67 Managing medicines for adults receiving social care in the community (NICE guideline Published: 30 March 2017 nice.org.uk/guidance/ng67 © NICE) as well as the guidance set out in *The Handling of Medicines in Social Care* (RPSBG 2007). In particular:

- Where a service user requires support with medications, the Provider will ensure that its staff have sufficient training and are competent to provide this support.

- The Provider will ensure that care plans are explicit in what actions must be taken to assist the service user with medicines and how they are to be protected from harm. Records are to be made of the assistance given on each occasion.

- When patients require assistance to decide which medicines are to be taken when and/or physical assistance is given to take a medicine, a written record must be made which includes the details of the medicines which were assisted with, including:
  - the name of the medicine
  - the strength of the medicine (if known)
  - the amount of each medicine used.

- The Provider will have systems in place to identify and analyse adverse events, incidents, errors and near misses, ensuring always that learning from these events is used to reduce risks and improve the service.

- The Provider will work collaboratively to optimise medications use for patients.

- Where required, the Provider will make arrangements for the safe storage of medications, to meet the service user's needs and protect others in the home (e.g. children)

- The Provider will monitor the use of medications to avoid hoarding or medications running out, notifying the individual responsible for ordering medications (patient, family member, community nurse) when supplies are running low. The provider will refer any medicines compliance issues to the GP, Community Pharmacy or Community Nurse as appropriate

- The provider will actively monitor for new symptoms or complications relating to medications, and refer to the GP or emergency services as appropriate.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements

Not Applicable

5.2 Applicable CQUIN goals

Not Applicable

6. Location of Provider Premises

6.1 Location(s) of Service Delivery

The Service will be provided in the Accommodation of the Service User unless there is specific reference to another place in the Individual Service Agreement or Care plan.

6.2 Days/Hours of operation

The Domiciliary Care Service is a 24 hour service, operating Monday to Sunday inclusive (including all national bank holidays). Individual care packages may include services provided during the day and/or night, defined in this specification as follows:

6.3 Day services

Domiciliary care services provided between the hours of 7am and 10pm.

6.4 Waking Night Sit

Where care workers are required to be awake on duty throughout the night between the hours of 10pm to 7am.

7. Individual Service User Placement

Not Used