# SCHEDULE 2 – THE SERVICES

## A. Service Specifications

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| **Service Specification No.** |  |
| **Service** | Norfolk Domiciliary Care Provision for NHS Continuing Healthcare (NHS CHC) |
| **Commissioner Lead** | NHS Norwich CCG |
| **Period** | 1st October 2016 – 30th September 2019 (with provision to extend for 2 years) |
| **Date of Review** |  |

1. Purpose
	1. The purpose of delivering NHS CHC within the domiciliary setting is to provide care for patients with a primary health care need who are eligible for NHS CHC. This includes enabling patients to achieve the best possible quality of life whatever their disease or disability, ethnic background, or sexual orientation. This will be achieved through the application of a holistic person-centered approach to care which is integrated seamlessly with all other health services, especially GP primary medical services, specialist palliative care services, mental health, learning disabilities and community social care.
2. Aims
	1. The aims of the NHS CHC within the domiciliary setting are:
3. To ensure that patients receive the most appropriate care.
4. To actively support holistic care of patients by defining clear health outcomes and objectives.
5. To utilise a proactive case management approach which includes regular monitoring and review, assessment of patient needs against NHS CHC criteria and where appropriate, undertaking comprehensive assessment and care planning for the NHS CHC process.
6. To assess patients’ capacity and support decision making in relation to health needs and to ensure that the needs and views of patients are central to developing and providing services.
7. To utilise primary care services to prevent avoidable admissions to hospital.
8. To develop effective communication systems at all levels of care feeding into, and out of the patient’s home.

#### Objectives

#### The objectives of the NHS CHC domiciliary care provision are:

1. To facilitate timely discharge from hospital via effective interagency early discharge planning arrangements.
2. To provide timely, high quality, evidence based care, including palliative and end of life care to patients.
3. To maintain the dignity and privacy of patients at all times.
4. To empower people to make informed choices and promote competent self-care where possible, enabling them to effectively contribute to their care management and optimise their independence.
5. To prevent and reduce health complications associated with immobility, disability or existing illness.
6. To liaise with the NHS CHC team, primary care services, social services, voluntary agencies, acute trusts and other professionals and agencies to ensure seamless care to patients.
7. To provide accurate high quality information and health education to patients, family members and carers in a culturally sensitive manner.
8. To utilise a case management approach which includes regular monitoring and review, working with the NHS CHC team for assessment of patient needs against the NHS CHC criteria and where appropriate, undertaking comprehensive assessment and care planning to support the NHS CHC process.
9. To utilise person centered approaches to care management and planning, by ensuring the use of appropriate evidenced based symptom/behavioral management strategies

#### Service Description

#### Norfolk Domiciliary Care provision for NHS CHC is available for adults (18 and over) who have been assessed as eligible for NHS CHC, have expressed a preference for care at home and whose needs can be best met in that environment. The provision will be accessible to anyone with a primary health need that can be safely and appropriately managed in their own home. Domiciliary Care provision will be available to everyone regardless of diagnosis disability, gender, ethnicity or culture for whom the responsible commissioner is a Norfolk CCG (as listed in the contract). It is anticipated that patients receiving NHS CHC-funded domiciliary care may have ongoing healthcare needs.

#### NHS CHC Domiciliary Care will be provided in addition to mainstream services, primary care, mental health, community health or specialist palliative care services.

#### Elements to be provided by the Norfolk Domiciliary Care Provision for NHS CHC will include the following, where relevant to the patient:

1. Process of dealing with referrals and pre-care provision arrangements
2. Care arrangements will be implemented within 48 hours of referral (including assessment of medically stable patients)
3. Formal review and evaluation (minimum monthly) by named registered nurse with senior support staff
4. Care coordination
5. Promoting health and wellbeing
6. Medication assistance
7. Multidisciplinary and interagency working (including proactive facilitation of timely hospital discharge within 24 hours of patient being medically stable)
8. Advocacy
9. Uphold security of physical environment
10. Risk assessment and management
11. Compliance with Local Authority and statutory safeguarding policy for vulnerable adults
12. Compliance with the Mental Capacity Act 2007, Deprivation of Liberty Safeguards (DoLS) 2009 and local protocols within DoLS
13. Support and engagement with family, carers and patient representatives
14. Infection control procedures
15. Dementia care
16. End of life care
17. Accompaniment for patients to attend external activities outside of their home which are conducive to their care and agreed as a task for the Provider as part of a care plan.

#### Geographic Coverage/Boundaries

#### Norfolk Domiciliary Care Provision for NHS CHC will be available to all people aged 18 and over for whom the responsible commissioner is a Norfolk CCG (as listed). This will include those who meet the criteria for access to services, such as asylum seekers or travelling families in line with; Who Pays, Determining responsibility for payments to Providers, August 2013, criteria.

#### Location(s) of Service Delivery

#### Patients’ usual place of residence.

#### Days/Hours of Operation

#### Twenty four hours a day, seven days a week.

#### Referral and Acceptance Criteria

#### The Provider will respond to referrals from the NHS CHC team to meet the needs of adults over 18 years of age regardless of diagnosis, culture, disability or gender. Patients will be eligible for NHS CHC in order to access the Norfolk Domiciliary Care Provision for NHS CHC.

#### The Norfolk Domiciliary Care Provision for NHS CHC will be available, when it is the judgement of the multi-disciplinary team and verified by the NHS CHC team, that care is most appropriately delivered in a patient’s usual place of residence.

#### Referral Route and Sources

#### Domiciliary care provision for NHS CHC will generally be in response to:

1. A referral from the NHS CHC Team for a person who has been determined to be eligible for NHS CHC.
2. A requirement for additional support to families and carers, particularly in relation to managing complex health and social care needs for NHS CHC eligible patients with long term conditions or entering the palliative and end of life care pathway.

#### Norfolk Domiciliary Care Provision for NHS CHC will be coordinated by the NHS CHC Team. All referrals will originate from this team. For Fast Track patients, the National Framework Fast Track tool is used and a detailed verbal handover will be provided.

#### Referrals should be discussed and assessed by the Domiciliary Care Provider’s clinician/senior healthcare practitioner prior to the referral being accepted. Where referrals have been discussed but not assessed by the Provider prior to the referral being accepted, Providers will accept the level of care needs determined by the NHS multidisciplinary team on the basis of the Decision Support Tool (DST).

#### The Norfolk Domiciliary Care Provision for NHS CHC works as part of the multi-disciplinary health care team providing NHS CHC. It may be that after consideration of the referral, or following the assessment of the patient, the referral is found to be inappropriate. In this situation, the Provider will ensure that the NHS CHC team is contacted to discuss alternative service provision.

#### Response Time and Prioritisation

#### Provider response to a referral from the NHS CHC team will be made by telephone within 4 hours to enable triage and prioritisation.

#### Care package commencement will generally be within 48 hours – but a longer timescale may be negotiated with the NHS CHC team depending on the circumstances.

#### The following core information will be provided by the NHS CHC Team: name, date of birth, address, telephone number, GP, diagnosis and prognosis if appropriate, care intervention required, anticipated care plan, confirmation of eligibility.

#### Patients will be formally assessed as soon as possible after service commences to confirm clinical needs and the most appropriate interventions.

#### Service commencement

#### Where the service commences on discharge from hospital, the Provider will endeavor to have a suitable representative available to meet the patient at their usual place of residence.

#### The Provider will have a suitable carer available to provide an initial assessment of a patient within four hours of care package commencement. Any significant changes in the patient’s clinical needs (on service commencing) will be communicated to the NHS CHC team clinical lead / NHS CHC Team.

#### The full personalised care plan for a patient will be completed within 72 hours. Any patient commencing services will be supported to register with a GP, if required. The responsible GP practice will be notified by the Provider of service commencement within 24 hours of service commencing.

#### Exclusion Criteria

#### Services not specifically stated as part of this specification are excluded. Any services provided outside of the service specification must have Commissioner’s explicit consent in advance. The Commissioner will not pay for any service not so authorised.

#### Service Model for Norfolk Domiciliary Provision for NHS CHC

#### NHS CHC in domiciliary settings will provide treatment, management and support for people with a primary healthcare need (as determined by the National Framework for NHS Continuing Care and NHS-funded Nursing Care, DoH, 2012), who are eligible for NHS CHC and will provide a service which enables them to remain in their home setting.

#### Norfolk Clinical Commissioning Groups will use a model, based on the level of need, for placing and pricing domiciliary care packages for people eligible for NHS CHC. The model is based on the Decision Support Tool (DST). Each tier contains detailed criteria which will be used by the multidisciplinary team to determine the notional care and support levels appropriate to the patient’s needs.

#### The level of care needs will be determined by the NHS multidisciplinary team on the basis of the assessment they have undertaken. An appropriate care package will be arranged to support a patient in their usual place of residence. This approach will be used for all NHS CHC patients requiring domiciliary care packages.

#### Patients will require care planning and treatment programmes to meet their specified health needs and outcomes, including the management of:

1. variable conditions/multiple pathologies
2. symptom management
3. management of long term conditions
4. promoting independence, health and wellbeing where possible
5. exacerbations/admission to hospital
6. contingency plans for care provision

#### The Provider will promote involvement of the patient in the design and implementation of their care plan.

####  The following table sets out the detailed criteria which will be used by the multi-disciplinary team to determine the notional care and support levels appropriate to the patient’s needs.

| Tier | The Patient’s Needs as determined by DST | Notional care and support levels |
| --- | --- | --- |
| Tier 1 | Patients will have one domain recorded as **severe**, together with needs in a number of other domains;**or** a number of domains with high and/or moderate needs. | * Most tasks undertaken by basic carers
* Some tasks undertaken by basic carers following training from health professionals
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| Tier 2 | Patients will have a total of two or more incidences of identified **severe** needs across all care domains;**and** needs in a number of other domains with high and/or moderate needs. | * Most tasks undertaken by basic carers following training from health professionals
* Some tasks undertaken by basic carers with additional specific support from qualified carers
 |
| Tier 3 | Patients will have a level of **priority** needs in any one of the four domains that carry this level;**and** needs in a number of other domains with high and/or severe needs. | * All tasks undertaken by qualified carers with specialist training with the support of basic carers
 |
| Tier 4 | Patient’s needs as determined by the DST will match Tier 1, 2 or 3 but have temporary highly complex needs that require either additional personal interventions or bespoke packages. | **Either** care and support levels specified by Tier 1, 2 or 3 plus additional personal interventions;**or** bespoke intervention or support to address highly complex care needs |

For Tier 4 either:

(1) care and support levels as specified by Tier 1, 2 or 3, plus additional personal interventions that are detailed in the ICA explicitly stating type of interventions (e.g. nursing, physiotherapy, healthcare assistant), the time of delivery, and cost per hour.

(2) or for patients with highly complex needs that require bespoke package(s) the ICA should fully detail the composition of these packages, explicitly stating type of interventions (e.g. nursing, physiotherapy, healthcare assistant), the time of delivery, and cost per hour.

#### Staffing

#### The Provider will ensure that an appropriately qualified, skilled and competent workforce, that meet all regulatory requirements, (Regulation 18: Staffing; the Health and Social Care Act 2014) is utilised to meet this service specification.

#### The service will be delivered by a mixed skill team, which includes professionally registered and unregistered staff.

#### The Provider will be responsible for ensuring that staff receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. Staff will also be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise.

#### Transfer of care and discharge planning

#### Patients will be discharged with the agreement of the NHS CHC team when:

1. The patient has been admitted to an inpatient facility due to a change in needs
2. The patient is transferring to another home based service or to family’s care.
3. The patient declines services and their capacity is such that they are able to make their own decision.
4. In the event of a patient’s death

#### Prior to a patient’s transfer to alternative Providers, a summary of care will be supplied to the new Provider and contact made with the patient’s GP to ensure seamless transfer of care.

#### In very rare circumstances it may be necessary to transfer a patient’s care due to clinical risk or non-compliance of the Provider. In these circumstances the issue will first be discussed between the NHS CHC team and the Provider, and every measure taken to resolve issues and negotiate an alternative plan of care.

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#### Hospitalisation of a Patient (elective and emergency treatment)

#### Where the patient is hospitalised and expected to return to their own home, the patient’s care package with the Provider will remain open to the patient for a period of 5 days – this is the standard retention period. Full payment of the Tier 1 rate will be made for the standard retention period.

#### Following the standard retention period, if the patient will need to return to the same Provider, a further period may be negotiated with the Commissioner. Full payment of the Tier 1 rate will be made for this extension period.

#### Once the standard or extension retention period has expired, the Provider will, with the agreement of the Commissioner, contact the patient’s representatives. Where there are no representatives for a patient, the Provider will follow legal requirements and any established procedures in order for the necessary arrangements to be made.

#### Activity Supporting Patient Admission into Hospital

#### When an admission to hospital is required, the Provider will ensure that the hospital receives all the relevant information regarding the patient. Upon admission into hospital the Provider will inform:

1. The patient’s next of kin/their representative as soon as possible;
2. The NHS CHC Team within three days.
3. The patient’s GP within 24 hours;

#### The Provider will maintain contact with the hospital throughout the patient’s admission.

#### In certain circumstances (e.g. where the patient has significant cognitive and behavioural needs requiring intensive support) the patient’s care package may continue when the patient is admitted to hospital. In these circumstances, the hospital will retain overall responsibility for the patient’s care until the hospital discharges the patient. Full payment of the contracted tier rate will be paid during this time. If the change in location of service delivery impacts on the cost of the care package, the Provider will contact the NHS CHC team to discuss and agree the changes and costs. The Provider will support the patient to access an appropriate method of transportation to the hospital.

#### Activity Supporting Patient discharge from Hospital

#### In the case of short term hospital admission, the Provider will liaise with the hospital to agree the date of the patient transfer and ensure they can meet the patient at their usual place of residence if required.

#### Where the patient’s hospital admission has extended beyond the standard retention period (5 days), the Provider will review the patient’s needs and care requirements prior to discharge to ensure needs and care requirements can continue to be met. Where a change in care is required to enable the Provider to do so, the Provider will contact and agree with the NHS CHC Team prior to service delivery. The Provider will liaise with the hospital to agree the date of patient transfer and ensure they can meet the patient at their usual place of residence if required.

#### Upon return to the patient’s home, the Provider will inform:

1. The patient’s next of kin/their representative of the transfer as soon as possible;
2. The NHS CHC Team within 24 hours

#### Staff should be knowledgeable about local services, to enable appropriate signposting. Staff should also be aware of the wider range of social care and social support services and be able to advise families (e.g. warfarin testing).

#### In exceptional circumstances when the Provider can no longer meet the needs of the patient, the Provider will notify the NHS CHC Team as soon as possible justifying the rationale for no longer being able to care for the patient.

#### Death of a Patient

#### In the event of the death of a patient, the Provider shall notify:

1. The patient’s next of kin/representative/executor as soon as is reasonably practicable;
2. The NHS CHC Team within 24 hours (by next working day).
3. The relevant local authority (social services).
4. The patient’s GP within 24 hours (by next working day).
5. If patient is found deceased by a carer, the Provider will follow their internal procedures and notify Police immediately if appropriate.
6. In the case of an unexpected death, the Provider will notify the NHS CHC Team as soon as is reasonably practicable.

#### The Provider will ensure that the patient’s medicines are retained for a period of seven days in case there is a coroner’s inquest. All patient related records will be archived and stored in a safe and secure place in line with the current NHS Record Management Code of Practice.

#### Where there are no representatives for a patient, the Provider will follow legal requirements and any established procedures in order for the necessary arrangements to be made (i.e. arranging the burial/cremation).

#### The Commissioner will cease payment for care to the Provider on the date of the patient’s death. However, it is recognised that in exceptional circumstances there may be services which the Provider may be required to deliver (i.e. the collection of equipment or arrangement of the burial/cremation). In these circumstances, the Provider will contact the NHS CHC Team to agree services, costs and invoices procedures.

#### Patients no longer eligible for NHS CHC

#### If the patient is no longer eligible for NHS CHC, 28 days notice will be given to the Provider. The Local Authority will be notified to undertake an individual assessment.

#### Evidence Base

#### NHS Continuing Healthcare and NHS-funded Nursing Care Framework (revised) (November 2012). DoH. London

#### Department of Health (2009) End of Life Strategy. DoH. London. Department of Health (2001) NSF for Older People. DoH. London Department of Health (2005) NSF for Long Term Conditions. DoH. London

#### Patient Experience Outcomes

#### Care will be offered according to recognised standards. This will be partially demonstrated through the Provider being registered with the Care Quality Commission (CQC).

#### Patients, families and carers are satisfied – the Provider will use surveys and any other agreed methods to evidence the satisfaction of individuals with the quality of care and their experience of receiving NHS CHC services. The results of these will be available to Commissioners if required.

#### Evidence of responding to patient/carer feedback – the Provider will be able to demonstrate that feedback has been sought from all individuals in receipt of NHS CHC through the service, and their carers about their care.

#### Individuals will be able to offer complaints and compliments about the service and have their complaints addressed and resolved.

#### System and Clinical Outcomes

#### The Provider participates fully any integrated clinical care pathways that are in place.

#### The service contributes to the reduction of unplanned admissions of CHC patients to hospital.

#### The Provider engages in clinical audit where required and contribute to improving clinical outcomes for NHS CHC patients (i.e. minimise falls, reduce infection episodes, avoid medication errors, and maintain skin integrity).

#### Quality of life Outcomes

#### Personalised individual care planning is in place for all patients, including end of life.

#### Patient goals are set and achieved with patients and families.

* 1. Independence is promoted for all patients.
	2. Health and wellbeing is optimised for all patients.

#### Applicable Standards

#### Safety of people using the service

#### The Provider is responsible for ensuring the safety of patients under the care of their staff. The Commissioners expect that they have robust risk management systems. These include incident reporting and learning and risk assessment. The Commissioners expect that the Provider will comply with the statutory arrangements for notification and investigation of serious incidents (Regulation12,13 of the Health and Social Care act 2014).

#### National Standards

#### The service will be delivered to meet prevailing national standards in relation to the provision domiciliary care:

1. Registration with the Care Quality Commission and adherence to its essential standards for quality and safety.
2. Applicable standards set out in Guidance and/or issued by a competent body (e.g. Dept. of Health, Royal College of Nursing).

#### Local standards

#### The Provider will ensure that the service is delivered in line with all legal requirements, national and local prevailing standards for Health and Care services including but not limited to:

1. Health promotion activities
2. CQC standards on Privacy and dignity
3. CQC standards on record keeping Infection Prevention and Control Incident Reporting
4. Risk Management Consent
5. Patient Experience and Complaints
6. Staff Training, Competencies, Supervision, Accountability, Accreditation, Annual Appraisal, and Continuing Professional Development
7. Clinical Audit
8. Equality, Diversity and Inclusion Safeguarding Adults and Children Information Governance
9. Agreed policies and pathways for mental health, dementia, learning disabilities, end of life and palliative care
10. Standards and guidance which may be issued by or on behalf of local Clinical Commissioning Groups.

#### Policies/procedures

#### The Provider is required to have the following and any other statutory documented policies and procedures in place:

1. complaints procedures
2. confidentiality policy
3. keeping written/clinical records policy
4. vulnerable adults protection procedures
5. safeguarding of children procedures
6. personnel policy and procedures
7. managing finance policy and procedures
8. prevention management and treatment of pressure sores
9. key working/named nurse and planning procedures
10. supply and use of equipment policy
11. end of life care, including support to the family
12. managing risk (including falls prevention) and resident choice
13. resident consultation and involvement policy
14. violence to staff/staff safety
15. whistle blowing
16. protection and use of patient information HSG(96)18
17. fire safety
18. Care Planning
19. cross gender care
20. health and safety
21. patient sexuality
22. medication management and safe administration policy
23. controlled drugs
24. dignity in Care
25. induction and ongoing training policy
26. staff code of conduct, including disciplinary and grievance policies/procedures (in line with the Skills for Care Code of Conduct Healthcare Support Workers and Adult Social Care Workers in England: [www.skillsforcare.org.uk/Standards/Code%20of%20Conduct/Code-of-Conduct.aspx](http://www.skillsforcare.org.uk/Standards/Code%20of%20Conduct/Code-of-Conduct.aspx))
27. Incident and accident reporting, including management processes
28. National care standards information (for all staff)
29. staff recruitment and retention policy
30. relevant personnel procedures, including equal opportunities policy
31. infection control and prevention
32. unplanned absence/absconsion
33. bullying and harassment
34. information governance policy (including staff responsibilities on handling person-identifiable data)
35. business continuity
36. Mental Capacity Act
37. Deprivation of Liberty
38. Challenging behaviour
39. Gifts policy

#### Notice Periods

#### Where the Commissioner gives notice

1. In the event of a safeguarding or patient safety issue, the Commissioner may transfer a patient or patients to another Provider without notice to the Provider. In these circumstances, Commissioners will not be liable for payment to the Provider for periods when patients are no longer in receipt of Services from the Provider.
2. In all other circumstances, if the Commissioner decides to transfer a patient to another Provider, the Commissioner will provide 28 days’ notice of such transfer in writing or e-mail to the Provider.
3. In the event the Commissioner transfers the patient to another Provider prior to the end of the Transfer Notice Period: the Provider shall receive payment, for the transferred patient for the period up to the end of the notice period.
4. If the Commissioner is unable to safely transfer the patient before the end of the notice period, the Provider shall continue to provide the Services to the patient until such time as the Commissioner transfers the patient and the Provider shall be paid for each day in excess of the notice period that the Provider provides Services to the patient. The NHS CHC Team shall regularly update the Provider regarding the anticipated date of transfer.
5. In the event that the patient, their representative, family or Carer informs the Provider that he or she wishes to change their care provision, the Provider must inform the NHS CHC Team.

#### Where the Provider gives notice

1. If the Provider wishes to give notice to the Commissioner regarding a patient, a minimum of 28 days’ notice shall be given in writing via the NHS CHC Team and the patient, their representative, family or carer.
2. If the Commissioner is unable to safely transfer the patient before the end of the notice period, the Provider shall continue to provide the Services to the patient until such time as the Commissioner transfers the patient. The Provider shall be paid for each day in excess of the notice period that the Provider provides Services to the patient. The NHS CHC Team shall regularly update the Provider regarding the anticipated date of transfer.
3. Where the Provider wishes to give notice on provision of Services to three or more patients, an extended notice period will be agreed in order that safe and appropriate alternative placements may be sourced.
4. Commissioners will not be liable for payment once Services are no longer provided.