SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	**1**
Service	**NHS Continuing Healthcare Services. Provision of Domiciliary Care for NHS Continuing Healthcare Patients**
Commissioner Lead	
Commissioner Support	**Kay McEvilly, Continuing Healthcare Business Operations Manager**
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

'NHS Continuing Healthcare' (NHS CHC) means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National framework for NHS Continuing Healthcare and NHS-funded nursing care (2018). Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness.

The care may be provided in a hospital, care home with nursing care registration or the service user's own home. Whatever the setting for the care, The NHS meets the full cost of the assessed health and personal care needed and this is provided free of charge to the individual.

The service specification is used to describe community based domiciliary care service to be provided in order to meet the domiciliary care needs of NHS Continuing Healthcare patients with personal and/or palliative care needs, who receive a NHS funded package of care in their own home and are registered with a Sandwell and West Birmingham GP.

The services will be provided in the patient's home and will be designed to enable patients at the end of life to exercise choice and achieve their preferred place of care and desired place of death, which for majority of patients is their own home or usual place of residence.

Service users who meet NHS Continuing Healthcare criteria have a 'primary health need' and typically have care needs that are complex, intense and unpredictable and therefore require high quality care delivered by well trained staff. The level of care will vary according to service user need.

This may be basic personal care or more complex care that requires the care worker to possess additional skills and competencies. In the majority of cases care will need to be provided by at least 2 staff with the level of care reflected by the staffing levels maintained.

Providers will be commissioned to provide care to service users with a wide range of medical conditions, that may require specific training to be delivered either by the provider or through a 3rd party identified by The Commissioner – e.g. where a service user is ventilated, the care worker may need additional specific training to be delivered by specialist nurses who are qualified in the care of ventilated service users. This is to enable a service user-centred service to be delivered.

All providers must be registered with the Care Quality Commission (CQC) to deliver Personal Care and have a registered nurse to oversee the home care packages, co-ordinate care and develop individual care plans, delegate and assign tasks where appropriate and provide supervision.

On-going eligibility is subject to regular review and assessment by the assigned NHS Continuing Health Care Case Manager.

Key definitions:

Palliative care

Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments for patients living with chronic long term conditions.

End of life

The phase 'end of life' ends in death. Definition of its beginning is variable according to individual patient and professional perspectives. In some cases it may be the patient who first recognises its beginning. In other cases the principle factor may be the judgement of the health/social care professional/team responsible for the care of the patient. In all cases, subject to the patient consent, the beginning is marked by a comprehensive assessment of supportive and palliative care needs. Professional judgement may be informed by the use of a range of indicators. They include:

- The surprise question – would you be surprised if this patient were to die in the next 12 months?
- Choice – The patient with advanced disease makes a choice for comfort care only.
- Need – The patient with advanced disease is in special need of supportive/palliative care.
- Clinical indicators – Specific indicators of advanced disease for each of the three main groups – people with cancer, organ failure, and elderly frail/dementia.

End of life does not normally begin earlier than one year before death and for most individuals it may come much later than that. However, in some cases discussions with individuals about end of

life may start much earlier e.g. at the point of recognition of incurability.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long term conditions in accordance with person-centred care plans, including any end of life plans	
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

The key service outcomes below are based on the NHS Outcomes Framework and Adult Social Care Framework.

- People with care and support needs have an enhanced quality of life
- People have a positive experience of care
- People are helped to recover from episodes of ill-health or following injury
- People are treated and care for in safe environments and protected from avoidable harm
- People are treated to minimise pain, discomfort and anxiety, whilst maximising quality of life

The overriding outcome to be achieved is to maximise choice for Sandwell & West Birmingham patients, their families and carers in their preferred place of care and to die in a place of their choice, which is increasingly patients own home. The implementation of this service specification should also enhance delivery of quality and equality. Whereby the provider will be required to work with SWBCCG to ensure that the service achieves the following outcomes and measures of success for the CCG and healthcare system by contributing to:

Service and System Outcomes

- Equity of access
- Robust risk management systems
- Integrated pathway development
- Improved co-ordination of community services

- Robust quality assurance system

Clinical Outcomes

- Effectiveness
- Safety
- Reduction in unnecessary hospital admissions
- Reduced length of stay in acute units
- Improved end of life care
- Increase in number of home deaths
- Reduction in hospital deaths
- Reduction in health inequalities

Service users and Carer Outcomes - More specifically for patients and carers

- Empowerment of the Service user
- Improvement in quality of life
- Improved support for family carers

All patients approaching End of Life:

- Have their physical, emotional, social and spiritual needs and preferences met
- Able to exercise choice in preferred place of care and place of death
- Assessed by a competent professional
- Have an individualised care plan
- Have their needs, preferences and care plan reviewed as their conditions change
- Know that systems are in place to ensure that information about their needs and preferences can be accessed by all relevant health and social care staff
- Have access to bereavement support
- Are treated with respect and dignity at all times
- All the services a person needs are effectively co-ordinated across the systems;
- The quality and effectiveness of care can be robustly measured

Staff Outcomes

- Robust initial training and education programme
- Continuing professional development
- Leadership
- Good retention rates

Economic Outcomes

- Cost effective service
- Good resource use

- Capacity and demand planning
- Value for money

3. Scope

3.1 Aims and objectives of service

The overall aim is to provide a responsive, high quality patient focused domiciliary care service for individuals assessed by the health professional as eligible for NHS Continuing Health Care, (NHS CHC), and who wish to receive a NHS fully funded package of care within their own home and meet the referral and acceptance criteria specified in this specification.

The primary aim of the services is to enhance the quality of life for service users and improve clinical outcomes where appropriate. In the delivery of the services the provider will work closely with family carers and Sandwell & West Birmingham CCG as well as the General Practitioners.

The Provider shall provide a reliable, cost effective, patient focused service of high clinical quality for NHS CHC service users who receive care in their own homes. The Provider shall ensure that the services reflect the ethos and standards outlined in the following Department of Health policy documents: National Services Framework for Older People, the NHS Constitution, Nursing Agency Regulations and National Minimum Standards, and the End of Life Care Strategy.

The Provider shall ensure that the service meets the following objectives:

Service User & Carers

- Prioritises the health, safety, quality of life and preferences of the service user and ensures these are central to care provision.
- Supports the service user to make informed choices about their care, as per the NHS Constitution. Including choice in their preferred place of care and achieve their desired place of death, which may be home by encouraging greater participation by patients and their families in the decision making process at all stages.
- To ensure delivery of person-centred and seamless care for patients, their families and carers at every stage and settings of patient journey and ensure they are fully informed about the illness.
- Supports the health, safety and quality of life of carers as outlined in the 2014 Care Act and National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018)

Provider Staff

- Care workers arrive on time, carry out the commissioned activities, interact with the service users and stay for the full time that is set out in the service user's care plan;

- Care workers have the required skill to meet the service user's needs, including end of life care;
- To ensure all documents, including referral forms, assessment and care plans, advance care directives to be completed fully and kept up to date to ensure effective communications between service users and staff, and staff to staff;
- To ensure patients are discharged back to the district/specialist nurses if they no longer meet the access criteria for palliative and supportive end of life domiciliary care;
- To implement a key worker / case manager system to improve delivery of care;
- To maintain dignity and respect for the individual at all times, taking into account needs of older people, those with mental health problems and physical and learning disabilities. Additionally, ensure adherence to The Mental Capacity Act and Safeguarding of Vulnerable Children and Adults;
- To ensure staff are supported to develop knowledge, skills and attitudes that are appropriate for delivering high quality end of life care. Staff to take responsibility for and recognise the importance of, their continuing professional development.

<u>Collaborative Working</u>

- To work in partnership with both the hospital and community specialist palliative care services to ensure delivery of appropriate care and support throughout the end of life phase;
- To work in partnership with generalist staff such as GPs and DNs and other service providers such as care homes, and voluntary organisations by facilitating and promoting evidence based practice, who deliver majority of palliative and end of life care in the community;
- To ensure that staff are aware of the pathway to access specialist palliative care nurses with appropriate skills, experience and competencies to manage patients dying from non-malignant diseases, such heart failure, respiratory disease and neurological conditions;
- To ensure that all stakeholders have access to contact details and are aware of the discharge criteria;
- To ensure innovation and continuous improvement in service delivery. This will include active engagement in schemes to improve the ongoing development and delivery of end of life care services in Sandwell & West Birmingham;
- To monitor and evaluate activity, including patient audits and carer satisfaction surveys on a regular basis and to make this information available to commissioners in line with performance management arrangements;
- To work in partnership with commissioners to ensure services provided meet the specified outcomes in particular with respect to choice, high quality and equitable access for patients,

their families and carers; and finally

Quality

- It is an imperative that The Provider will operate a care planning regime which is compliant with Sandwell & West Birmingham CCG's commitment to a model of care associated with its adopted standards:
    - The Supportive Care Pathway (SCP);
    - The Gold Standard Framework (GSF) for primary care and care homes; and
    - Advance Care Planning.
- To enhance the quality of life for NHS CHC Service user and to maximise long term health outcomes wherever possible.
- To deliver high quality care using advanced care planning ensuring service user's dignity and respecting patient's individual physical and cultural needs & emotional wellbeing.
- Active case management of service user aimed to reduce unscheduled acute admissions and improve co-ordination of community services especially end of life services.
- To address the policy standards and legislation relating to this group of Service users.
- Implementation and delivery of 24/7 Fast Track Service for NHS Fully Funded Continuing Healthcare and palliative care patients.

3.2 Service description/care pathway

NHS Continuing Health Care (NHS CHC) applies to a package of care that is arranged and funded solely by the NHS for people aged 18 years and older, who are assessed and meet the nationally determined NHS Continuing Healthcare criteria. Ongoing eligibility is subject to regular review and assessment by the SWBCCG's NHS Continuing Healthcare team. Patients who meet NHS CHC criteria have a 'primary health need' and typically have care needs that are complex, intense and unpredictable and therefore require high quality care delivered by well trained staff who can provide a flexible and reliable service. Care packages may involve long term care or short term interventions and are tailored to meet individual need.

The Provider shall be required to:

(a) ensure services can be provided 365 days a year, 24 hours a day and in accordance with a service user's care plan;

(b) ensure all service users are case managed and have an individual care plan;

(c) ensure individual care is subject to ongoing review and performance management.

Significant changes to the care plan that result in additional cost must be notified to the Commissioner and approved by the CCG's CHC Manager. The Commissioner is responsible for funding necessary equipment and providing the quality assured processes for accessing equipment.

It is the provider's responsibility to ensure that equipment is requested, maintained and that staff and carers are competent to use the equipment.

The provider shall not be expected to carry or administer controlled drugs. This aspect of the service user's care will be undertaken by community based health professionals which include; District Nurses, General Practitioners and specialist nurses such as Marie Curie Nurses and Hospice outreach teams.

The Provider shall ensure that:

- The services are reliable and consistent;
- It provides case management and supervision and support for all formal and informal carers;
- There is continuity of staff;
- It provides leadership and ongoing training and development for all staff;
- It supports and liaise with the District Nursing services and other allied health professionals who deliver care to NHS CHC Service users;
- It produces monthly reports to monitor service delivery to include hours worked, incident reporting, clinical or other agreed measures. These reports must be submitted to SWBCCG;
- The services are subject to robust clinical governance and risk management;
- They abide by CCG policies relating to clinical waste management;
- All staff will have recognised training in Palliative Care;
- There is effective communication between all agencies involved in the care of the Service user including voluntary services and any other commissioned services that may be provided by private providers or NHS services.

3.3 Population covered

The service specification describes the domiciliary care services provided to adults (over 18 years of age) registered with a Sandwell & West Birmingham GP practice ***and*** who have been assessed as eligible for

- NHS CHC Fast Track
- NHS CHC physical disabilities (including elderly frail)
- NHS CHC mental health adult (including dementia)
- NHS CHC learning disabilities adult (including Supported Living arrangements)

End of Life is not a separate service user group but is part of the above groups.

3.4 Accessibility/acceptability

The Provider shall comply with the following arrangements regarding the referral and acceptance of service users to the Service:

- A healthcare professional will forward on relevant paperwork to SWBCCG to request a package of care.
- The CHC team will ascertain provider capacity and forward the initial risk assessment and care plan with a proposed date of commencement.
- The provider shall allocate a team leader to the service user who will co-ordinate the assessment, produce a comprehensive individual care plan based on care need and patient derived goals and risk assessment implementing the service to agreed time scales, once the package has been approved.
- The provider shall introduce its carers to the service user and family prior to the commencement of the care package if times allows
- The team leader shall ensure that advice and support is given to the service user and their family
- The team leader shall ensure co-ordination of care and all relevant services in conjunction with CCG Health Professional.

3.4.1 Safeguarding

The Provider shall ensure that all policies and procedures relating to safeguarding are adhered to and that all staff are checked against the Disclosure and Barring Service and the PoVA List. The provider shall ensure that all staff have undertaken training appropriate for their professional role and receive any additional training necessary to care for specific service user.

3.4.2 Whole System Relationships

The Services are part of a wider integrated adult health and social care services. The provider and CCG will work in partnership with GPs, primary healthcare teams, acute providers, Local Authorities, community mental health team, the voluntary and community sector and independent providers.
Contact with relevant services will vary according to the needs identified in each service user's specific case. The provider shall co-ordinate all relevant services such as medical, specialist nursing, social services, chiropody, primary care services and ensures relevant and accurate communication is maintained.

The provider shall ensure that service user referrals to primary and community care are made in a timely manner and are followed up when a referral is not accepted/actioned.

3.4.3 Service Model

- The team leader shall co-ordinate and oversee the agreed care package
- The team leader shall ensure the delivery of an appropriate package of care that is service user focused and ensures the dignity and safety of the service user.
- The team leader shall review the package of care on a regular basis in accordance with the complexity of the case and feedback any changes to the CHS case manager, however all end of life clients will be reviewed initially at 4 weeks, followed by review at 3 months.

- In the case of end of life service users the Advanced Care Plan shall be written and co-ordinated by NHS staff, however it is vitally important that the provider's staff support the service user in achieving the objectives outlined in their advanced care plan (ACP)
- The provider's staff must be aware of the systems in place with respect to ACP and pass on important information to NHS staff
- Provider's staff must be able to identify the triggers that service users wish to discuss plans for their death and ensure that this information is shared with the appropriate NHS staff in order that the advanced care planning process can commence

3.4.5 Records and Reports

- Service user records shall be held in the individual's home and will be completed by carers.
- The team leader shall hold other records and reports at a designated office
- Access to files will be limited to the provider and the CHC Commissioner upon request.
- Clinical information can be shared with other NHS providers of care in accordance with the CCG policy on confidentiality and information governance.
- The provider shall implement all the relevant pathway adopted by the Commissioner, especially for end of life care
- Patients also have the right to access their files, following organisational policies and procedures

3.5 Any acceptance and exclusion criteria

3.5.1 Days/Hours of operation

The provider shall ensure that the services can be provide cover throughout 365 days per year, 24 hours a day and in accordance to an approved service user's care plan.

3.5.2 Referral criteria & sources

Only patients who meet the nationally agreed NHS CHC criteria are eligible for this service.
Only referrals made to the provider by the SWBCCG CHC team will be accepted as service users.

3.5.3 Referral route

Referrals to the Service will be made and accepted in accordance with the following arrangements.

- The service user is assessed by a community health professional and granted NHS CHC funding and requests a home care package.
- The community healthcare professional makes an initial risk assessment, discusses care options and produces an outline care plan.
- Assessor makes a referral to the CCG's CHC Team. The team will ascertain provider capacity and forward a copy of the CHC needs assessment, copy of the initial risk assessment and outline care plan along with a proposed date of commencement.
- The provider shall undertake Fast Track submissions; referral, assessment and care

planning, within 48 operational hours.

- The Provider shall undertake non–Fast Track, complex care assessments within 48 hours and care planning within 5 days negotiated with the case manager to ensure safe discharge and allowing for all equipment to be put in place.
- Should a crisis arise the Provider must be able to provide adequate care within 4 hours during 8am and 8pm and produce a care plan within 24 hours.
- Once the care plan ("Care Plan") is approved and the start date confirmed the Provider will liaise with hospital staff if the patient is an inpatient and SWBCCG and General Practitioner to finalise transfer.
- The provider shall ensure that a named team leader is assigned to the service user whose role and contact details are provided to the health professional/SWBCCG and General Practitioner
- SWBCCG will be notified by the provider of any changes to the discharge arrangements.
- SWBCCG will complete and forward a Service User Individual Placement Agreement detailing the commissioned arrangement including agreed costs.

3.5.4 GP registration

The provider will check that the service user is registered with a local GP upon commencement of care. Where the service user is not registered with a local GP the provider will inform the CCG within 30 calendar days.

3.5.5 Exclusion criteria

- This Service does not include patients who do not meet NHS Continuing Healthcare criteria
- It does not include NHS CHC patients who are in residential or nursing homes, or who are not registered with a General Practitioner associated with SWBCCG.
- The home care package may not be suitable on the grounds of risk and this must be discussed with the patient, the provider and SWBCCG's CHC Manager as well as any other relevant NHS staff at a case conference prior to discharge.
- No alternative medicine therapies will be funded unless provided directly through NHS commissioned services and must be recognised as clinically effective
- Service users and informal carers holiday costs will not be funded by the Commissioner.
- No food apart from PEG feeds will be funded by the Commissioner.
- The CCG will not fund transport costs that fall outside NHS provision

3.5.6 Response time & detail and prioritisation

- The provider must undertake an assessment within a maximum of 48 working hrs of referral
- A Care Plan must be submitted to the identified CCG Case Manager within a maximum of 48 working hours
- Wherever possible service users with end of life care needs should be a priority for the

provider and care may need to be organised and delivered within a maximum of 72 hours of referral

- If for any reason a service user's Care Plan is not implemented within 10 days a further clinical assessment of their needs should be undertaken and care plans revised accordingly. The same time scales as above will apply for implementation of the revised package of care.

3.5.7 Exceptional Circumstances

It is anticipated that the provider will be able to provide an appropriate package of care to meet the needs of all NHS CHC service users at home. However exceptional circumstances may arise whereby the provider is unable to meet the needs of a service user with exceptional needs. In this case the service provider must alert Sandwell & West Birmingham CCG immediately in order to discuss the situation.

3.5.8 Discharge planning from provider services

- If a Service user is re-assessed by a Sandwell & West Birmingham CCG Continuing Healthcare Nurse and no longer meets NHS CHC criteria then SWBCCG will no longer be required to fund the service from the date of transfer to an alternative provider or funder.
- Any ongoing package of care that is needed may qualify for funding by the Local Authority Social Services, subject to assessment.
- In some cases the cost of any ongoing package of domiciliary care may need to be met by the individual.
- Any ongoing nursing needs should be met NHS Community Services such as the District Nursing service.
- The transition of care should be seamless and will be co-ordinated by the team leader in conjunction with SWBCCG and a social care representative if appropriate.
- The service user and provider must be notified of the proposed changes to funding and involved when appropriate.
- The Commissioner's funding under NHS CHC rules will cease on the day the alternative service commences, which should be within 4 weeks following the reassessment.

- In the event of a service user's death the provider must notify the identified CHC Case Manager at SWBCCG within 24 operational hours. Funding for the package will then cease on the day of the service user's death. The provider shall ensure the return of any NHS equipment by notifying Home Loans/CCG who can arrange for collection of the items.
- If the service user or provider requests the discontinuation of the services a case conference must be held in order to ensure patient safety. In this event the community healthcare professionals and General Practitioners must be kept informed of the situation by the provider.
- In instances where the provider is no longer able to meet the needs of the service user and

care is to be transferred to an alternative care provider, the outgoing provider will provide a Care Transfer Plan.

- Care may also cease when a service user is admitted to residential care or moves out of the Commissioner's geographic area. In this case payment to the provider, for the package of care, ceases on the day of transfer.

3.6 Interdependencies with other services

The contact with relevant services will vary according the needs identified in each service user's specific case. However it is vital that the team leader co-ordinates all relevant services and ensures good communication is maintained and works within the data protection policy of the CCG. It is vitally important to ensure that the service is integrated into the end of life care pathway adopted by the CCG for CHC service user's receiving care in their home.

4. Applicable Service Standards

4.1 Eligibility

The CCG will conduct a CHC review to ensure the care package continues to meet the service user's level of care needs. The first review will be undertaken three months after initial eligibility and at a minimum, annually thereafter. The service user will be asked if they want family or carers to attend the review.

In the event the review indicates the level of care needs have decreased and the service user no longer meets the eligibility criteria, the CCG will refer the service user to the relevant Local Authority.

4.2 Service User needs

In agreeing to a care package the provider is agreeing to provide a care package to meet the assessed needs of the service user.

The care plan is a living document. The CHC team will be responsible for identifying the service user's care needs and developing a plan for the needs to be met. The provider will review, edit and develop the Care Plan to meet the identified needs and the efficacy of the Care Plan and its contents will be reviewed on an on-going basis. The provider will maintain a record of Care Plan reviews.

4.2.1 Care and Support Plan Contents

4.2.2 Medical Contents

The Care Plan medical contents

- Include the service user's diagnosis summary and relevant medical history
- Record the service user's medication and administration details for medication, including dosage and frequency
- Include clear instruction on medication management
- Are informed by discharge documents and mobilisation plans (eg. Transport, equipment, continence) and existing medicines administration records (MAR)

4.2.3 Person-centred contents

The Care Plan person-centred contents:

- Record the service user's needs and the corresponding provider requirements to meet those needs
- Record the service user's preferences
- Include a description of the service user's personal outcomes for the care package
- Include any relevant deprivation of liberty (DoL) statement or mental capacity statement
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4.2.4 Carer related contents

The care plan includes the roles and needs of any carers associated with the care package

4.2.5 Risk Assessment record

The Care Plan includes a Risk Assessment record of risks to carers, care workers, the service user and other persons associated with the care package. Risks may include (but are not limited to):

- Risks from the care environment
- Safeguarding risks
- Risks related to service user behaviour
- Risks assessments for nutrition (MUST), pressure sores, falls etc

The Risk Assessment record also includes any specific arrangements for managing and mitigating risks.

4.2.6 End of Life Care (ELC)

The Care Plan includes ACPs and Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs)/Advance Decision to Refuse Treatment (ADRTs) where applicable.

4.2.7 Additional Care

The provider will agree additional care in advance with the CCG Commissioner. The CCG will not be liable for the cost of additional care that was not agreed in advance. For all deviations from the NHS Standard Contract Terms & Conditions will be agreed in advance and documented in the IPA. The agreement, including any variations will be reviewed as part of the provider review.

In situations where additional care is required but there is insufficient time for advanced agreement, the CCG Commissioner will cover the cost of the care. The provider will notify the CCG Case Manager in writing the next working day. Such situations include emergencies or sudden significant changes in the service user's condition. The provider may be asked to provide evidence of the emergency or sudden significant change.

4.2.8 Contact details

The Care Plan should include contact information for family, carers and advocates in case of emergency.

4.2.9 Care Plan Review

Care Plans will be reviewed and evaluated at regular intervals by the team leader and a Continuing Healthcare Nurse Assessor. The frequency of the review will be decided by the team leader/SWBCCG on a case by case basis but should be no fewer than twice a year. The first

reassessment should take place within the first month of the commencement of the care package. A review can be done at any time and may be at the request of the patient, a family carer or a member of the multidisciplinary team.

The review of the care plan will include the following criteria:

- The relevance of the Care Plan
- The effectiveness of the Care Plan and outcomes
- Any unmet need
- Service user satisfaction with the care
- Treatment/rehabilitation/intensive support, frequency of support, and additional team support
- Activities of daily living, basics of daily living, social care support
- Medication- monitored and review plan
- Risk assessment procedures and crisis/urgent response
- Evaluation of team manager role
- Additional training needs of carers/staff is evaluated and implemented

4.3 NHS mail encryption system

The provider will ensure they can receive emails from SWBCCG and send electronic communications to the SWBCCG using an encrypted email system compliant with DPA. The provider will ensure there is always sufficient staff trained and available to access and acknowledge receipt of all secure emails within one operational day of the email being sent by the CCG.

4.4 Care package

The provider will agree to deliver a care package in which every service user will receive an individual, person-centred care package that is within the scope of the services that the provider can deliver. The appropriateness of the care package will be decided between SWBCCG and the provider.

If care workers do not show up for a session, that session will not be paid as part of the CCG payment.

4.5 Complaints and Issues

- Any complaints regarding NHS CHC funding and eligibility should be directed to the CHC Manager at SWBCCG and/or the provider.
- Issues regarding the provision of care will be directed to the provider and any complaints and untoward incidents must be reported as soon as possible within a 24hr period to the CHC Manager. This information will be shared by the CHC team with the SWBCCG's Clinical Governance Team. All complaints relating to the provision of care by the provider will be investigated by the provider in the first instance and a full written report sent to SWBCCG and named Clinical Governance Lead within fourteen days of complaint. It is the prerogative of the CCG to investigate further and the provider will be notified by the Commissioner of their intent to conduct a further investigation.

4.6 Service User's home

The provider is responsible for ensuring a safe working environment for care workers. As part of the Risk Assessment the provider will minimise and mitigate risks. The provider will enable care workers to make informed choices about risks.

In cases where the service user's home is not smoke-free, the provider will take steps to minimise the care workers exposure to smoke. Additionally, care workers may choose not to work in a smoking environment and the provider will support this without penalty. Where the service user's home compromises the ability to deliver safe and appropriate care the provider will report this to the CCG.

4.6.1. Visitors

The service user's relatives and friends are able to visit without restriction. The service user can refuse to see a visitor and the provider will support this decision.

The provider will not permit any persons to enter the service user's home without the service user's knowledge and permission except in cases of emergency.

The provider will agree visiting guidelines with the service user, carers and family upon commencement of the care. If appropriate and with the permission of the service user, the provider may maintain a visitor log, recording all visitors to the service user's home during the delivery of care.

4.7 Care Worker General Standards

Care Workers will not:

- Solicit or accept any gratuity, tip, or any form of money taking or reward, collection or charge for the provision of any part of the services other than the payment as agreed under the contract
- Accept any monetary gift, or gift over the value of £25. All gifts will be reported to the provider for approval. The provider will report any concerns regarding the acceptance of gifts to the CCG.
- Become involved with the making of the service user's will or with soliciting any form or bequest or legacy
- Agree to act as a witness or executor of the service user's will
- Become involved with any other form of legal document, except in circumstances agreed with the Commissioner
- Offer or give advice to the service user with respect to investments or personal financial matters

4.7.1 Care Worker Conduct & Performance

If a care worker is repeatedly late to care sessions, the provider will consider replacement of the care worker as long as this is not to the detriment of the service user's experience.

If a care worker does not attend a care session, the sessions will not be paid for by the CCG.

4.7.2 Property

Care workers will respect the fact that the care environment is the service user's home. Care workers will be sensitive to that environment and its contents.

Care worker will not:

- Consume the service user's food or drink without appropriate permission or invitation
- Use the service user's possessions e.g computer or telephone
- Use furniture or possessions in a way that the service user would not want
- Take responsibility for looking after any valuables on behalf of the service user

Any loss of or damage to service user's property should be immediately reported to the service user. In the event that care workers are responsible for damage or loss the provider will be responsible for compensating the service user.

4.8 Equipment

For all equipment funded by SWBCCG, the provider will use the equipment only for the purposes for which it is intended and in relation to the named service user.

4.8.1 Provider supplied equipment

The provider will supply infection prevention and control equipment in line with regulation 12.2 (f) of the 2014 Regulations.

The equipment will be supplied at no cost to SWBCCG. The cost of the equipment will be built into the cost of care. This equipment will include;

- Single use disposable gloves
- Single use disposable aprons, and
- Alcohol hand rub

The provider will safely and appropriately dispose of the above items and clinical waste in the service user's home.

4.8.2 Equipment supplied by SWBCCG

All required equipment identified in the delivery of the Care and Support Plan will be supplied by or via the CCG.

If the service user requires further equipment, the provider must contact the CHC team to discuss purchasing arrangements prior to supply.

The provider will:

- Check if the equipment needs to be maintained/serviced
- Arrange required maintenance/servicing or alert the CHC Case Manager to this need, and
- Not be responsible for the cost of maintenance

If the provider has mistreated or adapted equipment in any way the provider will be liable for the replacement cost, cost of repairs and/or any other incurred costs. Mistreatment includes, but is not limited to, unauthorised removal or use of equipment by another person.

4.9 Medication

The provider will;

- Agree policies and procedures for medicine management with SWBCCG Medicines Management Team
- Seek information and advice from pharmacist regarding medicines policies (including the management of over the counter medicines and alternative medicines)
- Store medicines correctly, dispose of them safely and keep accurate records (where responsible)

- Not control service user's behaviour with inappropriate use of medicines, in line with regulation 13.7 (b) of the 2014 Regulations, and
- Not give medicines prescribed for individuals service users to any other person

The provider's medicines management policies will:

- Include procedures for achieving the service user's preferences and ensuring that service user's needs are met, in accordance with regulation 9.3 (b) of the 2014 Regulations
- Meet regulation 12.2 (g) of the 2014 Regulations; and
- Include clear procedures for giving medicines in line with the 2005 Act

4.10 Service user information

The provider will ensure a Service User Guide is available and accessible to the service user. As a minimum the information should include:

- The provider's complaints and feedback procedures
- Contact details for the provider (including out of hours)
- Contact details for CQC
- Service User rights and provider obligations
- Care Workers procedures and policies
- Safeguarding contact details
- NHS Commissioner contact details
- Explanation how personal information will be used

4.11 Care Activity Log

The care activity log details, in English, the delivery of the care plan through all care provided to the service user during each care visit. This record is standardised and includes as a minimum:

- The date and time care was provided
- The type and frequency of the care provided
- Any relevant observations
- Any actions to be taken and the name of the person responsible
- The signatures of the care workers providing the care

The care activity log will be completed each occasion care is delivered. The provider team leader/manager will review the care activity log as required.

4.12 Care Worker training log

The Care worker training log records all qualifications, training and induction sessions received by care workers, including training for DNTs. Records will show the date training was completed, any relevant evidence and the signature of the trainer confirming the training was completed satisfactorily. The provider will complete the care worker training log as necessary and share it with the CCG as requested. Care workers must be trained to deliver the support tasks required, with the list of all appropriate training specified in the training log.

In order to safeguard the health, safety and welfare of service users, the provider must ensure at all times there are sufficient members of staff with the appropriate competencies, knowledge, qualifications, skills and experience to meet the needs of the people who use the service. The provider will ensure that there is a staff mix that reflect the needs of this Contract and the levels of experience of care workers should at least be consistent with National Standards. The includes the provision of a Registered Manager who is aware of and meets the requirements of the duties and responsibilities of a Registered Manager under these standards.

The competency of care workers employed is the responsibility of the Registered Manager and

should be maintained by regular participation in training, personal development activities and supervision.

All staff shall receive initial and on-going care training in relation to specific assessed needs of the service user. The following list provides examples but is not exhaustive:

- Food and hygiene
- Mouth care
- Basic life support
- Observational skills
- Catheter care incl. Supra pubic
- Documentation
- End of Life Care, Bereavement and care of the dying
- Safeguarding/DoL
- Dementia/Mental Health care
- Communication skills and assertive skills
- Confidentiality
- Health and safety
- Fire prevention
- Infection control
- Moving and handling
- Safety incident reporting
- Protection of Vulnerable Adults (PoVA)
- Skin care, Tissue viability and wound care

Additional training for complex needs patients to be agreed on a case by case basis.

The provider will ensure continuity of care and care worker to the service user whenever this is possible. The provider will also ensure that whenever regular care workers who are already known to the service user are unable to attend they will inform the service user and their family of such a change. The provider is responsible for ensuring replacement care worker is fully aware of any specific routines and preferences contained within the care plan. Replacement care workers should have been introduced to the service user and their family before they work alone with the service user for the first time.

The provider will ensure that care workers are provided with appropriate items of personal Protective Equipment (PPE) to promote good infection control standards and to comply with the Health and Safety requirements of the tasks they will be expected to perform under this Contract. This may include but is not limited to disposable gloves and aprons.

Any representative of the provider who visits a service user's home shall wear a form of photographic identification that shows their name and the name of the provider.

4.13 Incident Log

The provider will maintain a record of all Patient Safety Incidents (PSIs). The provider will notify the CCG as soon as is reasonably practicable of all PSIs. The notification will include actions taken by the provider to mitigate further harm or incident. The provider and CCG will develop an action plan to prevent further PSIs.

4.14 Resuscitation and medical emergencies

If a care worker identifies a medical emergency (this can include but is not limited to: suspected heart attack, significant falls, or overdoses) they will call an ambulance.

Where care workers are qualified and confident in the undertaking, they should administer CPR

where appropriate, being mindful of applicable DNACPR/ADRT.

Following this, the provider will contact the service user's family or advocate. The provider should the incident to the CHC Case Manager as soon as reasonably practicable.

4.15 Interruption to Care

4.15.1 Provider default

The provider is responsible for informing the CCG when commissioned care has not been delivered, the provider will provide an explanation. This may lead to formal action on the part of the CCG.

The CCG will not be liable for the cost of planned care not delivered due to provider fault.

4.15.2 No Provider default

Where the provider receives more than24 hrs notice no payment will be made for interruptions to care for reasons outside the provider's control. The provider will inform the CCG and adjust invoices accordingly.

Additionally no payment will be made if the provider could have reasonably known that care would not take place (eg, following service user hospitalisation or death).

Where an interruption to planned care is beyond the control of the provider, and the provider has not received 24 hrs notice, the CCG will pay the cost of the care for that day, but not for subsequent days.

4.16 Activities outside the home

The provider will support the service user to participate in activities of the service user's choosing, accompanying the service user as required.

4.17 Transport and Travel

In order to promote person centred solutions to transport which maximise independence, choice and control, the provider is required to make arrangements to meet transport and travel requirements of service users to and from hospital visits, however the use of patient transport should be used whenever possible. The provider should ensure transport is safe and suitable in meeting the service user's requirements.

4.18 Refusal of care

The service user may refuse care or participate in activities that prevent delivery of care if they have the mental capacity to do so. The provider will request the service user's right to make these decisions.

Where the service user lacks mental capacity to either give or refuse consent to care, a decision must be made in the service user's best interest. The best interest decision should be recorded.

4.19 Hospital stays

4.19.1 Unplanned admissions

- The provider will accompany the service user up to the point of admission
- The provider will share any relevant DNACPR/ADRT
- The provider will cease to provide services to the service user during the service user's hospital stay, unless the CCG makes alternative arrangements in advance.

The provider should inform:

- The service user's family as soon as reasonably practicable

- the CHC Case Manager and GP within 24 operational hours of any service user admitted to hospital for emergency care.

The CCG will not pay for any care during periods of hospital admission.

4.19.2 Hospital discharge

At the invitation of the CCG, the provider will review the service user's needs to ensure they can still be met by the provider, prior to the service user's discharge from hospital. If the provider can continue to meet the service user's needs the provider will agree any necessary revisions to the care Plan with the CHC Case Manager. The provider, will as far as is practical and reasonable, maintain continuity of care workers.

In circumstances where the provider can no longer meet the needs of the service user, the provider will notify the CCG as soon as possible explaining the rationale. In cases where care provision is to be provided by an alternative care provider, the outgoing provider will share a Care Transfer Plan.

4.20 Applicable national standards eg NICE, Royal College

The services should where appropriate comply with NHS central, regional and local policy and guidelines on end of life service as well as addressing the clinical evidence base relating to the provision of palliative and end of life. The following list is non-exhaustive:

- Care Quality Commission (CQC) Essential Standards for Quality & Safety
- Home Care: delivering personal care and practical support to older people living in their own homes (NG21)
- Falls on older people: assessing risk and prevention (NG161)
- Home care for older people (QA123)
- Managing medicines for adults receiving social care in the community (NG67)
- Pressure ulcers: prevention and management (CG179)
- Pressure ulcers (QS89)
- Moving between hospital and home, including care homes (a NICE quick guide)
- Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020
- End of Life Care: Helping people to be cared for and die at home (Public Health England, 2016)
- NHS Outcomes Framework (DoH)
- Mental Capacity Act (2005)
- Living well with dementia: A National Dementia Strategy (DoH, 2009)

Policy guidance relating to this document also includes the following Department of Health Policy documents:
The National Framework for NHS Continuing Health Care and NHS Funded Nursing Care (2018), National Service Framework: Older People

5. Applicable quality requirements and CQUIN goals

Baseline Performance Targets – Quality, Performance & Productivity				
Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Improving Service users & Carers Experience **Complaints** (Guidelines - Standards for Better Health 4th Domain)	The Provider will respond to complaints within statutory timeframes.	100% in accordance with regulations. Failure to comply in two consecutive months. Proportion outside of regulations with explanation. Evidence that practice has improved	Notification to CCG within 24 hours	Quarterly report Exception report to Performance Review Meeting and CHC Commissioning Manager
Unplanned admissions	The provider will undertake an on-going reporting system of all unplanned hospital admissions	Formal notification within a maximum of 48 hours	Report specifying reason for admission, time of day and length of stay	Quarterly report Exception report to Performance Review Meeting and Email to CHC Case Manager
Reducing Inequalities	The provider will ensure ethnic coding in 95% of all patients	Trajectory to achieve agreed %. Failure to achieve target in two consecutive months	Proportion accurately coded	Exception report issued to Performance Review meeting. Escalation to CHC Manager
Incidents, accidents and near misses and Serious Untoward Incident Reporting (SUI). All reporting to be done in accordance with existing CCG policies and within given definitions set by the CCG.	The provider will inform the CCG of all SUI's - number and nature of all incidents, accidents and near misses. Regular monthly reports of all incidents.	Verbal report within 24 hours Formal notification within a maximum of 3 days via email to Case Manager and CCG Quality Manager	Number of SUI's notified	Quarterly report Exception report to Performance Review. Full detailed report to CHC Manager. All SUI reports to be sent to the CCG Quality Manager or nominated deputy)

Clinical Complaints	The provider will inform the commissioner of all clinical complaints	Outline report of all clinical complaints including measures taken to prevent re-occurrence	Notification to CCG within 24 hours via Time 2 Talk	Quarterly report Exception report to Performance Review meeting. Escalation to CHC Commissioning manager for non-achievement
Missed/Late Calls	Provider will inform the CHC Team by email to CHC account of any incidents of missed/late calls	Breakdown of incidents; No of Missed Calls (any calls totally missed or late calls of over 60minutes) No of calls late by more than 30 minutes	Significant delays reported immediately	Quarterly Report Exception report to Performance Review meeting. Escalation to CHC Commissioning manager for non-achievement
Personalised Care Planning	All patients to have individualised clinical healthcare plan that is regularly reviewed in accordance to specification and updated by clinical case manager in consultation with, patient, carers and other relevant providers	100% of all patients to have care plan in place within 48 hours outlined in the referral pathway in appendix 1. Evidence of on-going regular review as outlined in the specification or agreed with the CHC Manager.	Receipt of initial care plan within 48 hours Quarterly report to outline case reviews	Quarterly reports Exception report to Performance Review meeting. Escalation to CHC Commissioning manager for non-achievement
Outcomes (Commissioning Assurance Framework, End of Life Outcomes)	Preferred place of death	% of patients who die in place of choice and number of deaths at home ,in hospital or hospice	Quarterly report	Quarterly report Exception report to Performance Review meeting. Escalation to CHC Commissioning manager for non-achievement

Referral Register	Provider to keep an on-going record of all cases referred to the provider to ascertain on-going capacity issues.	To be agreed with provider	Quarterly report	Quarterly report Exception report to Performance Review Meeting and CHC Commissioning Manager
Staff Changes	• **Management changes** Provider will inform the commissioner of any changes to management • **Staff changes** Provider will notify the commissioner of the No of staff leaving the organisation and the No of staff newly recruited	Formal notification within a maximum of 3 days Quarterly Report	Quarterly report	Quarterly report Exception report to Performance Review Meeting and CHC Commissioning Manager
Mandatory training & Competencies – percentage of staff receiving mandatory training (Guidelines – Standards for Better Health 3rd Domain)	Progress against agreed action plan	To be agreed with provider 100% of Clinical Case managers to be fully compliant with all training requirements. Baseline of staff skills to be provided and programme of on-going training to be negotiated.		Quarterly report Exception report to Performance Review meeting. Escalation to Commissioning manager
Compliance to CQC Standards	Provider to notify the commissioner of any significant changes to CQC registration Provider to supply a list of	Formal notification within a maximum of 3 days Full list to be provided with updates of any		Quarterly report Exception report to Performance Review meeting. Escalation to Commissioning manager

	policies in use	additional policies		