**Service Specification - Practice Requirements**

1. **Conflict regarding interpretation**
	1. In the event of a conflict in the interpretation of the Service Specification and the body of the contract, the body of the contract will prevail.
2. **Service Objective**
	1. The Contractor shall provide high quality and safe medical care, which is responsive and tailored to the needs of patients and consistently available to all patients in Lambeth Nursing/Older people Homes as listed in Schedule 2, part 2 irrespective of the Nursing/Older people Homes in which they reside.
3. **Service Aims**
	1. The Contractor understands that the aim of this service is to:
		1. Deliver a proactive patient centred model of integrated case management.
		2. Provide a responsive service which adapts over time to patient feedback and to changes in evidence concerning medical care for the Nursing/ Older Peoples Home resident.
		3. Provide clinical leadership to improve the overall quality of care for patients in Nursing/Older people Homes.
		4. Develop effective working relationships with Nursing/Older people Homes, acute hospitals, South London and Maudsley community services and other stakeholders which will allow the Contractor to effectively deliver against the objective of this service.
		5. Improve patient satisfaction.
		6. Improve end of life care and deliver Gold Standard Framework for Nursing/Older people Homes (GSFCH) which should deliver fewer hospital admissions and less numbers of deaths in hospital.
		7. Improve management of long-term conditions, frailty and dementia and take leadership in the systematic review of all aspects of care including geriatric syndromes such as nutrition, continence, skin care and falls & osteoporosis risk identification, response, and prevention.
		8. Improve the wellbeing of Nursing Home/ Older People residents.
		9. Improve medicines optimisation and reduce overprescribing of medicines, medical appliances, and medical devices that patients don’t need or want, or which may do them harm, supporting national patient safety targets.
	2. Improve communication between Nursing Home staff and primary care, increasing Nursing Home staff confidence to call the Contractor in urgent (but not emergency) and deteriorating cases.
	3. Support avoidable admissions to secondary care.
	4. Support reduction in Accident & Emergency attendances and associated admissions from Nursing/Older people Homes, with a focus on reducing Urinary Tract Infections (including increasing removal of unnecessary catheters), Chronic Obstructive Pulmonary Disease (COPD) respiratory management and falls reduction, as well as improving identification of the later phases of life and deterioration and utilising the Universal Care Plan and/or advance care planning as a communication tool with wider health Contractors on care plans.
	5. Reduce London Ambulance Service (LAS) call outs from Nursing/Older people Homes and increase in conveyance rates (recognising that call outs are more appropriate if the patient is conveyed).
	6. Support reduction in the number of falls in Nursing/Older people Homes.
	7. The Contractor will work to support and implement national and local medicines optimisation priorities, guidance and improvement schemes and have due consideration for safe, evidence based, value for money).
	8. Provide an immediate response to alerts of a localised outbreak e.g., Influenza Like Illness (ILI) in Nursing/Older people Homes.
	9. Develop and embed close working relationships with local geriatricians utilising advice & guidance and establishing formal and informal interface, training and case review with geriatricians and other specialists/professionals beneficial for individual patient care.
4. **Population covered**

4.1 The Contractor will be providing care to the registered residents of the listed (schedule part 2) Lambeth Nursing/Older people Homes.

1. **Service Location**
	1. The Contractor shall provide Services from the Nursing/Older people Homes that they cover as listed under the Practice Premises and Equipment section. It is the responsibility of the Contractor to make whatever arrangements are necessary to ensure it has appropriate facilities and access at the Practice Premises to meet the requirements for service delivery in accordance with Schedule 2.
2. **Access to Services**
	1. Opening Hours
		1. The Contractor shall be open and provide Reception Services during 8am to 6.30pm from Monday to Friday ("**Core Hours**").
		2. This is the minimum requirement and there is nothing in this Agreement that prohibits the contractor from opening and providing Reception Services outside of these Core Hours.
		3. The Contractor must provide full telephone reception services at the Practice listed Premises throughout the Core Hours.
		4. Telephone reception services will include but not be limited to:
			1. Answering the telephone by a practice staff member
			2. Booking visits over the telephone
			3. Answering and coordinating Patient or care home staff queries and requests.
			4. Signposting Patients or care home staff to services.
			5. Supporting registration of new patients; The telephone system should meet the requirements of Modern General Practice should make use of cloud based telephony systems, with the following features - Call back and queue position, call routing, welcome and queue messages, call recordings to support staff training, and response to complaints or incidents, reporting to support planning and demand management, live dashboard reporting, live dashboard reporting, flexible configuration and a bypass feature.
		5. The Contractor should receive and respond to communications from patients, carers, patient advocates and those with Power of Attorney and the Nursing/Older people Homes during Core Hours. All parties can request a visit for the patient. The Contractor will follow due process and agreed procedures as set out in the Standard Operating Procedures (SOP) which will be agreed between the Commissioner and Contractor within three months from the date of the contract.
		6. For routine requests, the request is required to be resolved within a maximum of five working days from receipt of call or by 6.30pm on Mondays for calls received on Fridays, or sooner as clinically appropriate.
		7. For urgent requests, the Contractor will provide the services as outlined in Urgent Provision section.
		8. The Contractor acknowledges that a routine request is defined as a request that could have been anticipated in advance, for example, for prescriptions, medication changes/reviews, or a patient who has become gradually unwell.
		9. An urgent request is defined as a request that could not have been anticipated in advance, for example, acute exacerbation or an urgent situation not requiring a blue light ambulance or where the patient is assessed to be at risk of conveyance. The Contractor shall agree a protocol with all Nursing/Older people Homes for urgent and routine requests.
3. **Staff**
	1. A duty General Practitioner / Nurse Practitioner shall be available throughout the Core Hours to provide urgent visits.
	2. A practice-based Pharmacist will form part of the core team to undertake structured medication reviews, support medication queries, clinical and governance audit and implementation of local and national medicines optimisation priorities.
4. **Improving Access Through Use of Technology**
	1. The Contractor shall implement the following national and local digital platforms; accordingly, to a timetable agreed with the Commissioner:
		1. Online Patient access to records.
		2. Online booking and cancelling of appointments; The commissioner recognises that the standard practice of Patient Online appointment booking services may not be appropriate for this Service in virtue of the main care provision being undertaken through visits to Nursing/Older people Homes. The Contractor is expected to work to best practice and include Care Contractors and patients in selecting a solution that best meets the need of patients.
		3. Online ordering of repeat prescriptions; The Contractor shall take reasonable steps to ensure that it transmits at least 80% of appropriate repeat prescriptions to the patients nominated pharmacy electronically using Electronic Prescription Services (EPS), unless the Care home asks for a paper prescription, or the necessary legislative or technical enablers are not in place.
		4. Electronic repeatable prescriptions ([electronic Repeat](https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/prescribing-and-dispensing/electronic-repeat-dispensing-erd) [Dispensing](https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/prescribing-and-dispensing/electronic-repeat-dispensing-erd)) and Proxy Access are set-up for patients where appropriate.
		5. Co-operate with any developments in prescription ordering which will allow care home staff to order online repeat medication on behalf of residents (namely [‘proxy access’](https://www.england.nhs.uk/ourwork/clinical-policy/ordering-medication-using-proxy-access/) ordering)
		6. Utilise Prescribing Decision Support Tools and other local medicine optimisation and population health management support tools such as OptimiseRX, EZ Analytics, PrescQIPP, ePACT2 etc.
		7. Electronic consultations.
		8. Electronic receipt of Secondary Care Contractor discharge summaries and subsequent post-event messages.
		9. Creating and Maintaining Universal care plans on the relevant platform
		10. The Contractor shall proactively offer registered patients access to the services referred to in paragraph above, providing clear information necessary to do so. The Contractor shall take reasonable steps to ensure that at least the local borough average of registered patients is using each of the online services described above.
		11. The Contractor shall issue passwords and verify the identity of registered patients wishing to access the services above, as recommended by guidance from the Royal College of General Practitioners (RCGP).
		12. The Contractor shall ensure that its pages on [www.NHS.uk](http://www.NHS.uk) are updated regularly, and always provide complete and accurate information regarding the practice.
5. **Patient Registration**
	1. The Contractor shall comply with Clause 31 regarding registration and deregistration of patients, noting the additional Clauses below.
	2. The Contractor shall accept an application for inclusion in the Contractor's List of Patients made by or on behalf of any resident of a Nursing Home and listed Older Peoples home in the London Borough of Lambeth that meets the criteria required to be met by either a registered patient or a temporary resident.
	3. The Contractor shall only refuse an application where the applicant does not reside in a designated Nursing & Older People Home.
	4. The Contractor shall work with Nursing/Older people Homes to set up a system for alerting the Contractor of the arrival of new residents at the Home and give the Contractor the opportunity to satisfy itself with the sufficiency of medical information provided. The responsibility for ensuring that sufficient medical information from the previous practice is available remains the responsibility of the Contractor, the Nursing/older Home will work in a collaborative way with the Contractor to share any information of mutual interest for the benefit of improved patient care.
	5. Where the Contractor is notified that a Nursing/Older Home resident is intending to move out of a Lambeth Nursing Home into other accommodation that is not covered by this Service, the Contractor shall advise the patient that they will no longer be eligible to be registered with this Service and that they should be supported through the Nursing Home Contractor, where appropriate, to apply for registration with another Contractor of Essential Services (or their equivalent) in their new residential / catchment area.
6. **Registration Pathways**
	1. The Services are built around the following registration pathway for patients:
		1. Stage 0: The resident, carer or family are prompted to register with the Contractor for the provision of the Services. The following steps shall be taken at this stage:
			1. Nursing/Older people Homes will provide information to the residents, carers and/or family as appropriate on the options for registration.
			2. Nursing/Older people Homes will ensure that ‘informed Patient Choice’ is maintained; it must be mentioned at this stage that it is not mandatory for the patient to be registered with this service.
			3. The Contractor shall provide information to the Nursing/Older people Homes to ensure that they have the full information available for residents, carers or families (as appropriate) to make an informed decision. The information includes on service delivery and how to access the service should they need to.
			4. The Contractor will be responsible for building the local relationships, networks and pathways with the Nursing/Older people Homes and marketing their service to Nursing/Older people Homes and the residents of the Nursing Home.
		2. Stage 1: Where the resident decides to register with the Contractor for the provision of the Services, the Contractor shall support the resident during the registration process.
		3. Stage 2:Nursing/Older people Homes will provide to the Contractor details of patients’ previous GP. The Contractor shall register and care for those residents at the Nursing/Older people Homes who elect to register with the Contractor. The Contractor shall:
			1. Register all new patients using the GMS1 form and agreed medical pro-forma, to be agreed with the commissioner prior to the service commencement.
			2. Obtain information on the patient’s medical history from the Nursing Home, GP2GP electronic records, Lloyd George Medical Records as appropriate. The Contractor may want to develop a working relationship with the Nursing/Older people Homes to collect and share information of mutual concern for good patient care; however, the responsibility for sourcing the information for patient registration remains with the Contractor.
			3. Provide written and verbal information to the patients, carers, families or those holding relevant Powers of Attorney (as appropriate) on the level of service provision following registration. Such information shall include details of what the patients can expect in terms of service delivery and how to access the service should they need to. In particular, the Contractor should highlight how to contact the Contractor should they need to, and the communications should also take account of patients who lack mental capacity.
		4. Stage 3: The Contractor shall provide the Services to the patients in accordance with this Agreement. In addition, the Contactor shall:
			1. De-register and mark as deceased any patient whose death the Contractor is aware of, or is notified of by another source, within fourteen (14) days of becoming aware of or otherwise being notified of the patient's death, whichever is earlier.
7. **Temporary Residents**
	1. The Contractor acknowledges that a temporary patient is anyone placed in a care home on a non-permanent basis including (but not limited to):
		1. Discharge to Assess (DTA)
		2. Step Down
		3. Rehabilitation
		4. Respite
	2. For Temporary Residents, the pathway above should be followed with the following arrangement.
	3. The Contractor will establish robust communication plans with the Temporary Residents current GP to ensure continuity of services.
	4. At stage 3 of the pathway, the Contractor shall:
		1. Register all Temporary Residents for the period required but no longer than up to three (3) months as a temporary resident. For patients who intend to stay at the Nursing/ older Home for longer than three (3) months, the Contractor shall consider whether the patient should be registered as a permanent Registered Patient.
		2. Make necessary arrangements to accommodate repeat respite patients and provide them with good quality care.
		3. As per clinical appropriateness complete a full ‘New Patient Assessment’ for any Temporary Residents staying for more than fourteen (14) days.
		4. Use the same medical pro-forma (subject to the Commissioner’s prior approval) to register Temporary Residents as they do for Registered Patients. It is important that as much information as possible is captured on these patients to improve patient care.
		5. Obtain information on the patient’s medical history; and
		6. Provide written and verbal information on the level of service provision to the patient, carer and family. The information should include details of the service to be provided by the Contractor and how the patient, carer and family may access the service if they need to.
		7. At stage 3 of the pathway, the Contractor shall work with the Nursing/Older Home and the Temporary Resident’s GP to deliver their care plan, unless there is a reported change in their condition which requires a new care plan to be drawn up. In this case, the Contractor shall undergo the same care planning steps as with any other patient registered under this Agreement. The Contractor will establish a written protocol for liaising with the Temporary Resident's GP to ensure consistency in implementing their care plan.

1. **Service Level Description**
	1. The Contractor shall provide a GP-led primary care service to registered patients. Nursing Home residents have more complex health needs than the general population and therefore require an enhanced level of service.
	2. The Contractor shall address these health needs through the provision of the following service elements to the patients:
		1. Essential Services, which comprise the following:
			1. the provision of certification of death services in accordance with paragraph 6 below; and
			2. Additional Servicesas defined in the GMS Contracts Regulations
			3. Enhanced Medical Services as defined in the GMS Contracts Regulations.
	3. Further Agreed Services in the Service Specification as set out in Schedule which comprise the following:
		1. Medical care services: consisting of ‘new’, ‘routine’ and ‘follow-up’ assessments for patients post exacerbation or periods of ill- health.
		2. Medicines optimisation services: consisting of both ‘new’ and ‘routine’ structured medication reviews; and
		3. Urgent medical care provision (in-hours) 8.00am to 6.30pm Monday to Friday: including telephone calls to be triaged and urgent calls to be responded to within 15 minutes of call being logged.
		4. Training Nursing Home staff on catheter care and maintenance, wound care (including pressure sore care and stoma care, if applicable).
		5. Shared care drug monitoring.
		6. Phlebotomy services.
		7. Screening and vaccination services
		8. Any other Locally Commissioned services such as Medicines Optimisation, Long Term Conditions, Immunomodulatory etc.
	4. NHSE Network Contract DES Services, subject to any future national changes which comprise the following:
		1. Structured Medication Review and Medicines Optimisation within the Primary Care Network Directed Enhanced Service (PCN DES)
		2. Enhanced Health in Care Homes
		3. Any further additions in accordance with the relevant directions.
2. **Certification of Death Services**
	1. The Contractor will provide certification of death services and support for bereaved relatives and meet the obligations established in the 2024 Death Certification Reforms and Medical Examiners legislation.

1. **Enhanced Medical Services**
	1. The Contractor shall provide a model of medical management which is focused on prevention and proactive case management.
	2. The Contractor shall maintain a presence in nursing and residential Nursing/Older people Homes as mutually agreed. Weekly home rounds will be delivered in accordance PCN DES.
	3. Nursing Home for Extra Care Housing, the is Contractor will establish a bi-weekly ‘clinic’ on location at the Extra Care Housing residence for residents to book into and for the Contractor to see patients they identify as requiring care.
	4. The Contractor shall liaise with the Nursing/Older people Homes to agree times for routine / regular visits.
	5. The Contractor shall provide these medical assessments during clinical sessions that include ward rounds, face-to-face time with patients, and meetings with relatives. Clinical sessions must be completed by a general practitioner, nurse or practice-based pharmacist.
	6. The Contractor shall conduct medical assessments of all patients' physical and mental health, including sensory status, nutrition and hydration status, skin care, activity and functional status, medication and preventative health measures (including falls prevention), at a clinically appropriate time and frequency.
	7. The Contractor will work with the specialist nursing teams to ensure there is a nutritional screening policy in place with a named staff member taking responsibility for this policy within the Nursing Home. The Contractor will also ensure collaborative working across specialist nursing teams in managing pressure ulcers and falls.
	8. The Contractor will explore technical solutions that connect clinicians with Nursing homes Nursing/Older people Homes using high-definition cameras. The system enables clinicians to observe an individual’s ability to feed themselves unaided, without requiring a call-out. They can then work with the home and person involved to ensure they are supported to eat and drink well.
	9. Patients’ medical records will need to specify the date of the medical assessments undertaken.
	10. The Contractor shall work with Nursing/Older people Homes to maintain a copy of each medical assessment on the patient file in the Nursing Home or on an electronic system that may be remotely accessed by the Nursing Home.
	11. The Contractor shall document in patients’ medical records anything that changes the personalised care and support plan of the patient, and this should be communicated to the Nursing Home. Where advance care planning (ACP) is completed, the contractor will document this on Universal Care Plan (UCP) to aid communication with other health care professionals.
	12. The Contractor shall ensure continuity of staffing to ensure that both Nursing Home staff and patients have consistent contact with the same GPs, nurses and others working for the Service, as far as possible and reasonable. This will also allow the Service staff to become familiar with the processes in different Nursing/Older people Homes and to build relationships with Nursing/Older people Homes over time.
	13. The Contractor shall provide end of life (EoL) care, which shall consist of care coordination and advanced care planning support for significant decisions with patients, their carers, family or power of attorney and the Nursing Home. The Contractor should ensure any personalised care plan (PCP) is available on an electronic system such as the UCP care planning tool and provide evidence to the Commissioner and the Nursing/Older people Homes of the same.
	14. In a small number of cases, subcutaneous hydration may be considered for patients on an EoL pathway. These cases should be agreed in partnership with the Nursing/Older people Homes and the patient’s carers and relatives. The Contractor shall prescribe and liaise with the Nursing/Older people Homes to ensure processes for monitoring patients are in place for homes that have the governance processes in place to deliver this.
	15. The Contractor will provide regular, timely and skin, pressure care and wound care for Nursing Home patients and will support Nursing Home Nurses with providing the same specifically in Nursing/Older people Homes, to avoid occurrence of pressure sores. The contractor will systematically review wound care management and facilitate appropriate use.
	16. The Contractor shall have a proactive approach to identifying and managing patient dehydration and malnutrition. The Contractor shall consider de/hydration and mal/nutrition during all patient contacts and assessments and work with Nursing Home staff and community services e.g. GSTT LAMP Community Dietitians to manage patients and administer saline drips and diet/dietary supplements as required. The contractor will record baseline measures relating to weight and hydration when admitted and will review regularly and as part of routine care/MDT review processes to enable earlier identification of need for dietician input or need for review of the trajectory of patients’ clinical condition
	17. The Contractor shall identify and manage hypertension in patients and have due regard for stroke prevention and best practice in stroke aftercare where applicable.
	18. The Contractor shall have a proactive approach to identifying and managing long- term conditions. The Contractor shall consider long-term condition management during all patient contacts and assessments and work with Nursing Home staff and relevant community services e.g. Community Diabetes Team, Heart Failure Team, Integrated Respiratory Team, Care Home Team to manage patients and administer recommended medicines within local guidelines.
	19. The Contractor must be flexible and meet with patients and their carers, family or power of attorney to discuss any issues of concern. This should be at a time convenient to them including outside of normal office hours if unavoidable.
	20. The Contractor shall develop an operational policy to facilitate contact to and from the patients' carers, family or power of attorney (as appropriate).
	21. If the Nursing Home has a conversation with the patient that may impact on the care needs of the patient, the Nursing Home is expected to communicate this to the Contractor and the Contractor shall put in place measures enabling this communication to take place.
	22. The Contractor shall have minuted meetings with the Nursing Home staff to discuss issues relating to the services and registered patients. The Contractor shall have such meetings at least once per annum and more frequently as deemed appropriate for the maintenance of a high-quality service. The contractor shall, upon reasonable notice from a Nursing/Older People Home, participate in any additional meetings the Nursing/older people Home and/or the Commissioner considers necessary.
	23. The contractor will undertake governance processes to enable improvement in care provision including admissions, mortality and incident reviews.
	24. The Contractor shall conduct a face-to-face medical assessment with all new Patients at the next available ward round on their admission to the Nursing Home (‘Initial Assessment’) within 7 days of admission Shorter would be better. The Initial Assessment shall involve the patient, their carers and/or family as available and appropriate and include, but not be limited to the following:
		1. If possible, the taking of a full medical history from the patient, the patient's family or carer if necessary.
		2. Carrying out of an alcohol dependency screening.
		3. The carrying out of a cognitive assessment using General Practitioner Assessment of Cognition (GPCOG) Score or Mini Mental State Examination where appropriate.
		4. Carrying out of a structured medication review including medicines reconciliation from previous care setting.
		5. An assessment of the following:
			1. Frailty.
			2. Pain.
			3. Falls and bone health.
			4. Depression and anxiety.
			5. Mental health issues including dementia; and Behavioural and psychological symptoms of dementia (BPSD)
			6. Sensory loss (hearing, sight and touch).
			7. Clinical observations.
			8. Vital signs.
			9. Continence.
			10. Skin and pressure care.
			11. Quality of life (QoL) and activities and known wishes and preferences with reference to care plan drawn up with Nursing/Older Peoples Home staff.
			12. Prior resus and ACP and plan for what is required discussing for ongoing care.
			13. Malnutrition score.
			14. Review of EoL care issues in collaboration with the Nursing Home.
			15. Assessment of long-term conditions (LTCs) and co-morbidities.
			16. The agreement of a medical care plan for the patient in collaboration with the patient's family or carers and the Nursing Home staff.
			17. The agreement of a medical management plan for future anticipated events, for example, exacerbation of LTC or deteriorating health.
			18. The development of management plans for EoL care.
			19. The management of any investigations deemed necessary, for example, blood tests.
			20. Issues relating to wound care management.
		6. The Nursing/Older people Homes should take a lead on the assessment of the following and make referrals to appropriate clinicians as required:
			1. Issue viability, skin integrity, including a review of Braden or Waterlow score.
			2. Equipment for example, pressure relieving mattresses, cushions, slide sheets, heel boots, that may be required by the patient.
			3. The patient's mobility.
			4. The patient's continence and any catheter requirements.
			5. Safeguarding issues or mental capacity.
			6. Nutrition and hydration (including a review of Malnutrition Universal Screening Tool (MUST)); and
			7. activities of daily living.
		7. Should the Contractor notice anything of relevance in respect of the above during delivery of this Contract, it should notify the Nursing Home of its findings and endeavour to discuss the above elements with the Nursing Home to ensure these important aspects of shared care are coordinated for the benefit of improved patient care.
		8. To note, the Commissioner is committed to working to improving the quality of care for Nursing/Older people Homes residents in line with the [NHS framework for enhanced health in](https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf) [Nursing Homes](https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf) through joint working with the Contractor, Nursing/Older people Homes and other relevant healthcare Contractors.
		9. If any aspect of the Initial Assessment is not completed, the Contractor must record the reason in the patient's medical records together with details about whether it can be completed in the future.
		10. The Contractor shall conduct a further medical assessment once every six months for all patients which includes the consideration of all issues contained in an Initial Assessment (‘Routine Review’). The Contractor may carry out the Routine Review at the same time as a Medication Review.
		11. The Contractor shall conduct a further medical assessment for all patients who have an emergency admission or elective admission to hospital or those patients who experience an exacerbation of LTC or require follow-up for any other reason as clinically appropriate of readmission to care home. After admission, the Contractor shall follow up all patients of the post-admissions assessment (‘Follow up Review’). The Follow Up Review shall:
			1. Be conducted face-to-face with the patient.
			2. Include a re-assessment of the patient's medication to reflect the outcomes of the detailed Structured Medication Review; and medicines reconciliation; include a revised medical care plan to reflect any changes in level of need; and
			3. Include a revised patient management plan, as necessary and updating UCP where there are significant changes.
		12. The Contractor shall ensure processes are in place to be kept informed by Nursing/Older people Homes of any newly admitted respite patients. Where a healthcare professional such as the Nursing Home manager or nurse indicates that a new respite patient would benefit from a medical assessment, the Contractor shall undertake an assessment of that patient that will allow the Contractor to make a clinical judgement regarding the level of care required for the duration of their stay. A standard agreed medical pro-forma should be used. For any respite patient who stays in the home longer than two weeks, the Contractor should endeavour to undertake an assessment of patient, regardless of whether any specific concerns have been raised.
2. **Medicines Optimisation**
	1. The Contractor shall provide pharmaceutical care and medicines optimisation for all patients. The Contractor acknowledges that, medication dispensing is outside the scope of the Service.
	2. With an ageing population, the use of multiple medicines (polypharmacy) is increasing. Between 30-50% of medicines taken for LTCs are not taken as intended. Medicines optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team. This supports patients to improve their outcomes, take their medicines correctly, avoid taking unnecessary medicines, reduce medicines wastage and improve medicines safety.
	3. Structured Medication Reviews (SMRs) are designed to a be comprehensive and clinical review of a patient’s medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
	4. National and local guidance and best practice recommendations will follow and include, but are not limited to:
		1. [The Right Medicine: Improving Care in Nursing Homes (Royal](https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Publications/The%20Right%20Medicine%20-%20Care%20Home%20Report.pdf?ver=2016-10-19-134849-913) [Pharmaceutical Society, 2016)](https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Publications/The%20Right%20Medicine%20-%20Care%20Home%20Report.pdf?ver=2016-10-19-134849-913)
		2. [Medicines Optimisation in Care Homes (NHS England March 2018)](https://www.england.nhs.uk/wp-content/uploads/2018/03/medicines-optimisation-in-care-homes-programme-overview.pdf)
		3. [Managing Medicines in Nursing Homes (NICE SC1, March 2014)](https://www.nice.org.uk/Guidance/SC1)
		4. Good for you, good for us, good for everybody A plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions (Department of Health and Social Care, September 2021.
	5. The Contractor shall undertake structured medication reviews (SMR) as outlined in the [Network Contract DES specification](https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation/): a Pharmacist should be available within the contractors team to support regular SMR completion with input from the Integrated Care Homes Pharmacy Team for residents with complex medicines optimisation needs.
	6. For all permanent residents of the Nursing/Older people Home who are registered with the Contractor for the provision of the Services, and temporary residents of the Nursing Older People Home staying longer than fourteen (14) days, who must receive medicines reconciliation and a new structured medications review on registration.
	7. For all permanent residents of the Nursing/Older People Home who are registered with the Contractor for the provision of the Services, and temporary residents of the Nursing Home staying longer than fourteen (14) days, who must receive a full structured medication reviews on a regular basis. The frequency of reviews should be determined as part of the holistic patient review and led by the patient’s needs, but intervals should be no less than 12 months (in line with NICE SC1 Section 1.8.4 as amended from time to time) and should be more frequent (at least every 6 months) for patients on one or more repeat medicines.
	8. For all permanent residents of the Nursing/Older people Home who are registered with the Contractor for the provision of the Services, and temporary residents of the Nursing/Older people Home who are discharged from acute hospitals, mental health inpatient units and intermediate care, who must receive a medicines reconciliation by the practice pharmacist as soon as possible upon discharge (this can be virtual rather than face to face) and a follow-up structured medication review within five (5) working days of discharge back to the Nursing Home;
	9. For all Patients initiated on EoL care medication, a follow-up medication review within three (3) working days of initiation of the EoL care medication.
3. **Prescribing**
	1. All patients should receive appropriate drug therapy when necessary and in the most appropriate setting. The contractor will ensure safe evidence-based value of money use of medicines, medical appliances and devices in line with national or locally approved guidance.
	2. Without prejudice to this contract, the Contractor shall:
		1. Prescribe safe evidence based, value for money medicines and medical devices in accordance with national and local guidance including:
			1. NICE clinical and technology appraisal guidance and quality standards.
			2. Department of Health and Social Care directives relating to prescribing [South East London](http://www.lambethccg.nhs.uk/news-and-publications/meeting-papers/south-east-london-area-prescribing-committee/Pages/default.aspx) [Integrated Medicines Optimisation Committee](http://www.lambethccg.nhs.uk/news-and-publications/meeting-papers/south-east-london-area-prescribing-committee/Pages/default.aspx) (SEL IMOC); and Clinical effectiveness South East London (CESEL) management guidelines and recommendations.
			3. [General Medical Council Good Practice Prescribing Guide](https://www.gmc-uk.org/-/media/documents/Prescribing_guidance.pdf_59055247.pdf) (especially relating to the prescribing of specials).
			4. Local improvement schemes relating to medicines optimisation and long-term condition management.
			5. Shared care [South East London Joint Medicines Formulary](http://www.selondonjointmedicinesformulary.nhs.uk/default.asp).
			6. Patient group directions, Care Quality Commission (CQC) Standards.
	3. In addition to the above, the Contractor shall:
		1. Be expected to operate within prescribing budgetary constraints and with appropriate regard to the management of NHS resources.
		2. Have a system in place that ensures regular structured medication review for all patients and have documented evidence of review and any actions taken.
		3. Ensure the prescribing of medicines only by a suitably qualified Independent Prescriber within their scope or medical doctor, who will seek specialist medical doctor advise as appropriate.
		4. Where relevant, levy NHS prescription charges and collect NHS overseas visitors’ charges in accordance with the overseas visitors hospital charging regulations in accordance with guidance contained in [NHS cost recovery - overseas visitors (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1186860/nhs-cost-recovery-overseas-visitors_september2023.pdf) as amended from time to time.
		5. use NHS Prescription Forms (for dispensing in the community); and comply with guidance relating to safe and secure handling of medicines as detailed in [Professional Guidance on the Safe](https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines) [and Secure Handling of Medicines](https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines).
		6. Respond to and action local and national safety alerts including those from the NHS [Central](https://www.cas.mhra.gov.uk/Home.aspx) [Alerting System](https://www.cas.mhra.gov.uk/Home.aspx) or National Patient Safety Alerts.
		7. Work in collaboration with the Commissioner's Medicines Optimisation Team to deliver safe, evidence based, value for money medicines optimisation.
		8. The Contractor will hold a meeting with Nursing/Older people home staff, the community pharmacist from the supplying community pharmacy, contractor’s care home pharmacist and the integrated care home pharmacy team to discuss any key issues and actions related to medicines optimisation at least once per year.
		9. Ensure the prescribing of controlled drugs, benzodiazepines and antipsychotics are kept to a minimum and regularly reviewed and reasons for prescribing these are documented.
		10. Work collaboratively with the GSTT LAMP Community Dietitians and SEL Prescribing Support Dietician Service to ensure appropriate prescribing, use and avoidance of waste in oral nutritional supplements
		11. Meet the standards for safe repeat prescribing and ensure there is a robust system for re-ordering of repeat prescriptions including considerations for reducing waste. Actively implement systems which support safe and value for money prescribing e.g. electronic repeat dispensing; proxy access/ordering; Prescribing Decision Support Tools e.g. Optimise Rx.
		12. Maintain an up-to-date and comprehensive copy of each structured medication review in the patient’s file in the Nursing/Older people Home and in the patient’s GP records.
		13. Have access at the home to electronic prescribing systems or as needed a physical prescription pad and implementing the guidance on management and control of prescription forms (cfa.nhs.uk).
		14. Monitor the use of repeat prescriptions and ensure that they are clinically appropriate.
		15. The Contractor shall undertake joint audits of prescribing-dispensing and administration with the Nursing/Older people Homes and where appropriate dispensing community pharmacist, at least annually.
	4. Prescribing for outbreaks of illness:
		1. The Contractor will provide medical assessment and if required post-exposure prophylaxis with antiviral drugs for influenza like illness (ILI) for residents in a Nursing/Older people Homes in accordance with requirements of NHS England to provide such a service locally.
		2. The Contractor will refer to the NHS South East London Integrated Care Board (ICB) Procedure for the management of localised community outbreaks of influenza (both in and out of season) with antiviral medicines.
		3. Identification of a localised community outbreak is completed by #UK Health Security Agency South London Health Protection Team (UKHSA SLHPT) who will investigate the report from a localised community residential setting to verify the criteria of an outbreak of influenza-like illness (ILI) are met, as per national guidance. If antiviral medicines are recommended, the UKHSA SLHPT will contact the Contractor to provide information on the location of the outbreak, the approximate number of individuals that require medical assessment for antiviral medicines within the outbreak.
		4. The Contractor should notify the ICB’s Public Health lead for Lambeth of the outbreak within 24 hours and respond to the UKHSA SLHPT report as a matter of urgency. The Contractor will deploy a clinician to attend the affected Nursing/older peoples Home. within set timeframes as per the NHS South East London ICB Procedure for the management of localised community outbreaks of influenza (both in and out of season) with antiviral medicines (see separate guidance).
		5. Other outbreaks such as scabies - Other outbreaks of communicable infection or an infection control incidents Local and national policies should be followed such as [Nursing Homes: Infection Prevention and Control](https://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published) [(Department of Health, 2013](https://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published) as amended in accordance with guidance from time to time.
4. **Shared Care High Risk Drug Monitoring**
	1. The Contractor shall provide a shared care/high risk drug monitoring service for all medicines prescribed by the service requiring regular monitoring Shared care/high risk drug monitoring may additionally be required for drugs prescribed by specialists Shared Care/transfer of care guidelines developed by the SEL IMOC should be used where possible but should not be limited to these.

1. **Oral and Optical Health**
	1. Every resident’s oral health will be assessed as part of the holistic assessment of needs and personalised care and support planning process.
	2. The Contractor will work with the Nursing Home to ensure they have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for adults in care homes <https://www.nice.org.uk/guidance/ng48/chapter/Recommendations>
	3. Every person’s oral health should be enquired after and/or observed regularly by Nursing home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in Nursing/Older people Homes.
	4. Staff employed by Nursing home Contractors should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals and maintain this knowledge and skill through ongoing professional development.
2. **Mental Health**
	1. The Contractor and the Nursing Home should ensure that all residents are screened regularly for common mental health disorders such as depression, anxiety, severe mental illnesses and delirium. Dementia – and should make use of the primary care dementia diagnostic tool to improve rates of diagnosis.
	2. People with mental health needs should have access to a wide range of therapies and specialist support services for their psychological needs. Liaise with CHIT team(Slam) and the GP should be supporting care for BPSD - behavioural and psychological symptoms of dementia This may include psychological therapies through Improving Access to Psychological Therapies (IAPT) services for people with common mental health problems including co-existing long-term physical health conditions and medically unexplained symptoms e.g. group or individual cognitive behavioural therapy and/or community mental health services which provide NICE recommended therapies for people with severe mental illnesses.
3. **Communication with other Contractors / services**
	1. The Contractor will ensure that any recommendations or changes in a patient’s treatment should be communicated by secure NHS mail (or telephone if urgent) as soon as possible.
	2. Or within 48 working hours (for example to the community pharmacy). Communication should include reasons for the recommendations / changes and any required ongoing monitoring.
4. **Monitoring**
	1. The Contractor will be expected to review prescribing data from ePACT2 to ensure that prescribing is in line with SEL Joint Medicines formulary and other guidance mentioned above, supporting safe, evidence-based value for money prescribing.
	2. The Contractor will be required to undertake audits of prescribed medicines as requested by the Commissioner.
5. **Urgent Provision**
	1. The Commissioner acknowledges that the Contractor is not an emergency response service. Emergencies should be handled in the usual way through an emergency 999 call to London Ambulance Service. The Contractor shall provide an enhanced general medical service for Nursing Home patients and their families by providing timely access to primary care for those who require it. The Contractor should make maximum use of UCR services.
	2. The Contractor shall:
		1. Provide urgent access to a comprehensive primary care service during Core Hours which shall comprise the following.
		2. Provide telephone advice, triage and support for the Nursing/Older people Homes and/or patients and/or their families during Core Hours.
		3. Where necessary, provide a ‘call-out’ to the Nursing/Older peoples home to provide direct care to the patient that is the subject of the call; and
		4. Provide services to visiting patients that require urgent access to primary care whilst the Contractor is on-site at the Nursing Home performing its other duties.
		5. Work with the Nursing/Older people’s Homes to facilitate responsive and appropriate access of urgent care.
		6. Respond to all urgent enquiries (whether over the telephone or whilst on-site at the Nursing/Older people Homes) within fifteen (15) minutes after receipt of a request and advise on the course of action.
		7. Once an urgent enquiry is received, the Contractor shall triage and prioritise the enquiry and discuss the management plan with the Nursing/Older Home to resolve the enquiry. Where it is deemed clinically appropriate to visit the patient, the visit will be undertaken on the same day as receipt of the urgent enquiry.
		8. Clinical judgement will be used to prioritise the order of visits undertaken each day.
		9. Respond to all requests from the UKHSA SLHPT for clinical assessment of influenza like illness and antiviral prophylaxis in a timely manner in line with SEL ICB local procedure.
		10. Establish robust systems for handover to the out of hours Contractor and systems for feedback from the out of hours Contractor.
		11. Establish systems for feedback to the Nursing/Older people Homes, families and patients where issues cannot be resolved.
		12. Use the Pan London Electronic Personalised Universal Care Plan.
		13. Maintain a profile on NHS Pathways Capacity Management System (CMS) Directory of Services, as used by NHS 111 or any other relevant system.
		14. Ensure that it submits the Special Patient Notes for all patients and in particular patients thought to be at the End of Life. This should support the handover to NHS 111 and out of hours Contractors.
6. **Post discharge procedures**
	1. The provision of this part of the Services should include provision of the following by the Contractor:
		1. Procedures performed in casualty e.g. lancing of boils, as clinically appropriate.
		2. Undertaking requested actions on the discharge summary as deemed clinically appropriate.
		3. Supporting discharge and transfers of care, as set out in the Network Contract DES.
		4. Delivery of post-operative wound care in line with the Lambeth PMS Premium commissioned services.
7. **Phlebotomy services**
	1. SEL ICBcommissions the provision of blood sampling for patients in residential Nursing/Older people Homes and extra care housing from the community healthcare Contractor. It is noted that the following services are being provided by the Nursing/Older people Homes:
		1. The obtaining of a venous blood sample as required, based on medical need, for patients in Nursing/Older people Homes only.
		2. Provision of the blood sampling for patients in Nursing/Older people Homes at an appropriate time, location and accessible environment.
		3. Provision of all equipment necessary to provide the service for patients in Nursing/Older people Homes. This includes ensuring that the equipment meets the requirements of the local laboratory service.
		4. Maintaining a record of all samples taken, blood tests requested and results on practice clinical systems which must be auditable.
		5. The provision to the patient, carer and the Nursing Home of information regarding how to obtain test results, how long they must wait for the results and who to contact with any queries; and
		6. Ensuring that there are arrangements in place for the safe transfer of samples for testing and to ensure that this is done in a timely manner.
		7. The Contractor acknowledges that, they would only be required to take blood samples in the case of an emergency.
8. **Screening Programmes**
	1. Subject to the screening service being available in Lambeth, the Contractor is responsible for encouraging and supporting patients to attend or participate in the following national screening programmes where relevant:
		1. Breast Cancer screening.
		2. Abdominal aortic aneurysm screening for men, in their 65th year by ultrasound screening.
		3. Diabetic Eye Screening Programme all known diabetics; and
		4. Cervical screening (if clinically appropriate).
		5. Dementia Screening (screen all at risk patients for Dementia and refer on appropriate to the Memory Clinic, having completed appropriate screening test as per [NICE Clinical Guidance 42](https://www.nice.org.uk/Guidance/CG42)).
9. **Vaccinations and Immunisations**
	1. The Contractor shall deliver the following vaccination programme in line with clause 3A of the contract and in accordance with “Immunisation Against Infectious Disease "The Green Book" (as amended from time to time):
		1. Influenza vaccination in line with the Lambeth PMS Premium commissioned service.
		2. Pneumococcal vaccine (PPV) with PPV booster.

* 1. In addition, the Contractor will deliver any other prevailing vaccination programme relevant to this cohort, as set out in national schedules, for example, the shingles and COVID 19 vaccination, as would be expected of a general practice.
	2. When vaccinating patients, the Contractor must:
		1. Have attended relevant training in the administration of vaccines.
		2. Be competent to manage anaphylaxis.
		3. Have attended CPR training in the past 12 months; and
		4. Carry an anaphylaxis kit with them.

1. **Patient, Family and Carer Experience**
	1. The Contractor shall consider the issues with engaging with this vulnerable population, many of whom may have physical or cognitive impairment. Families, carers, and patient advocates play an important role in the lives of these patients and their views and input into the service delivery is important.
	2. Patient Participation Group (PPG) - The Commissioner recognises that the service is being mainly delivered in Nursing/Older people Homes across Lambeth and that the close family, and/or carers of patients are often closely involved in Supporting Nursing Home residents.
	3. The standard PPG group model does not align with this service, however a forum for a patient/carer/Nursing Home voice needs to be in place as detailed below. The Contractor shall establish and encourage on an ongoing basis an active Patient Participation forum. As the Contractor will be covering 11 separate sites, the forum can be virtual. The forum shall meet at times determined by its members but as a minimum in Year 1, one (1) time, and four (4) times in subsequent Contract Years. Areas for discussion shall be determined by the members and should include, but not be limited to: Challenging to engage the several NHS providers but their support would be crucial to a PPG working across the borough.
	4. The PPG will focus on the following:
		1. Access, including opening hours and telephone access.
		2. Clinical services.
		3. Practice performance.
		4. How patient feedback is being used to improve clinical standards.
		5. How patient feedback is being used to improve patient experience.
		6. How Nursing Home feedback is being used to improve clinical standards and experience.
	5. Patient Surveys and ongoing feedback - Contractor Staff shall involve patients, carers, and their family members in the assessment of the Services and seek feedback on an on-going basis with respect to patient experience and outcomes and shall take appropriate action based on their feedback. For Friends and Family Test (FFT) We recommend using a combination of methods to ensure the opportunity to give feedback is as accessible as possible. Providers are still required to include at least one free-text question alongside the standard FFT question.
	6. The Contractor shall develop an annual locally administered survey of patients and carers /family using a survey approved by the Commissioner. The Contractor shall take appropriate action based on the results. The survey results and the action plan should be available to view upon reasonable request from the ICB.

1. **Other services**
	1. The Contractor shall not sign up for any current or future Local or Direct Enhanced Service without approval from the Commissioner. The Contractor and Commissioner will discuss and agree sign-up to any current or future Local or Direct Enhanced Services upon award of Contract.
2. **Immediately Necessary Treatment**
	1. The Contractor shall provide primary medical care services required in Opening Hours for the immediately necessary treatment of any person falling within the following conditions described below who requests such treatment, for the period specified.
	2. A person falls within this paragraph if they are a person:
		1. Whose application for inclusion in the Contractor’s list of Registered Patients has been refused and who is not registered with another contractor of Essential Services (or their equivalent) in the Practice Area.
		2. Whose application for acceptance as a Temporary Resident has been rejected.
		3. Who is present in the Practice Area (Lambeth Nursing Home) for less than twenty-four (24) hours.
		4. The period referred to in 6.1 above is:
			1. In the case of 21.2.1 above, fourteen (14) days beginning with the date on which that person’s application was refused or until that person has been registered elsewhere for the provision of Essential Services (or their equivalent), whichever occurs first.
			2. In the case of 21.2.2 above, fourteen (14) days beginning with the date on which that person’s application was rejected or untilthat person has been subsequently accepted elsewhere as a Temporary Resident, whichever occurs first; and
			3. In the case of 21.2.3 above, twenty-four (24) hours or such shorter period as the person is present in the Practice Area.
		5. The Contractor acknowledges that, Essential Services provided by the contractor are deemed to include wound care and suture removal.
3. **Equity of Access**
	1. The Contractor shall provide a responsive Service tailored to the needs of the patients. The Contractor must be mindful of issues of access and equity which are particularly prevalent in older and housebound people.
	2. The Contractor shall:
		1. Not discriminate between patients on the grounds of age, gender, sexual orientation, ethnicity, disability, or any other non-medical characteristics.
		2. To follow the Accessible Information Standard [NHS England » Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/).
		3. Utilise available professional translation services (note, a translation service is provided at the costs of the Commissioner).
		4. Provide appropriate translations of materials describing procedures and clinical prognosis, where it is normal procedure to provide such materials in English or for the languages recommended by the Commissioner as being the most common languages spoken by patients who are likely to use the Services.
	3. Take reasonable steps to proactively deliver health promotion and disease prevention activities to all Patients including those from seldom heard from groups [20200727 How to coproduce with seldom heard groups.pdf (healthwatch.co.uk)](https://network.healthwatch.co.uk/sites/network.healthwatch.co.uk/files/20200727%20How%20to%20coproduce%20with%20seldom%20heard%20groups.pdf). The Contractor acknowledges that a seldom heard group shall include but not be limited to the following:
		1. Those who do not understand written or spoken English.
		2. Those who cannot hear or see or have other disabilities.
		3. Black, Asian, or multiethnic communities.
		4. Older people.
		5. Those who have mental illnesses.
		6. Those who misuse alcohol or illicit drugs.
	4. The Contractor acknowledges that to improve equity of access for black Asian and multi ethnic (“BAME”) Communities, it is important to collect information on ethnicity and first language due to the need to consider cultural and religious beliefs and, language providing appropriate care packages and the need to demonstrate non-discrimination and equality of access to service provision. The Contractor shall therefore be required to record the ethnic origin and first language of all Registered Patients.
4. **Patient Dignity & Respect**
	1. The Contractor shall:
		1. Ensure that the provision of the Services and the Practice Premises protect and preserve Patient dignity, privacy and confidentiality.
		2. Allow Patients to have their personal clinical details discussed with them by a person of the same gender, where required by the Patient and if reasonably practicable.
		3. Provide a chaperone for intimate examinations if requested to preserve Patient dignity and respect cultural preferences; and
		4. Ensure that the Contractor Staff and anyone acting on behalf of the Contractor always behaves professionally and with discretion towards all Patients and visitors.
5. **Informed Consent**
	1. The Contractor shall comply with NHS requirements in relation to obtaining informed consent from each Patient as notified to the Contractor by the Commissioner from time to time prior to commencing treatment including the following as amended from time to time:
		1. Department of Health Good Practice Reference guide to consent for examination or treatment (second edition) - GOV.UK (www.gov.uk)
		2. Health Service Circular HSC 2001/023 as amended or replaced from time to time; and
		3. Seeking Patients' Consent - The Ethical Consideration: GMC November 1998 as amended or replaced from time to time.
6. **Referrals**
	1. The Contractor shall:
		1. Record all referrals in the patient record using the appropriate SNOMED Codes and monitor and minimise inappropriate referrals and hospital admissions in line with the ICB annually agreed priorities and practice specific work plan.
		2. Co-operate with service contractors carrying out the Out of Hours Services to ensure safe and seamless care for patients, including providing information on, as a minimum, a weekly basis and, where relevant, daily to such contractors carrying out the Out of Hours Services on Patients that may require their services or who have special clinical requirements.
		3. Provide complete and comprehensive information to support any referral made and comply with, where appropriate, any directions provided by the ICB concerning the format or composition of referrals including, where relevant, instruction to direct referrals to a third party for clinic booking and/or clinical triage.
		4. Use robust clinical pathways for referral, where these are agreed with other local healthcare Contractors and/or issued by the ICB.
		5. Routinely collect and assess data about the appropriateness of the Contractor’s referrals, using audit and peer review to share learning.
		6. Implement national referral advice including relevant Referral Guidelines for Suspected Cancer and NICE guidance.
		7. Ensure urgent suspected cancer referrals are sent via the e-Referrals System and received by the relevant trust within twenty-four (24) hours.
		8. Develop and implement policies in relation to nurse and nurse specialist referrals where nurses have an extended role in the treatment and investigation of patients with specified diseases; and
		9. Implement and operate the NHS e-Referral Service at point of referral for services and provide a booking facility (in accordance with the NHS Choice agenda).
7. **Interdependence and Co-operation with other services**
	1. The Contractor shall have regard to all primary care commissioning policies (as updated from time to time at both local and national levels and including the ‘Call to Action’ deliverables) and ensure that co-commissioning arrangements are implemented and amended from time to time (including arrangements for co-commissioning or joint commissioning).
	2. The Contractor will provide an integrated and fully supported primary health care team to work in partnership with all other NHS and non-NHS healthcare contractors and stakeholders (including, but not limited to, district nurses, social services, mental health services, acute trusts and acute trust laboratories, community geriatricians, community pharmacists, hospice services, other GP Practices and Healthcare Professionals and local voluntary and third sector organisations) on the same basis as the majority of other GP Practices in the ICB area. This will include participating in any local collaborative models of working.
	3. The Contractor must work closely with a range of stakeholders including but not limited to.
		1. Nursing Home owners, contract holders, managers and staff (clinical and non-clinical).
		2. Patients, their carers and families.
		3. Secondary Care clinicians including geriatricians.
		4. Community services e.g. District Nurses, Tissue Viability, Community Allied Health Professionals and Care Services, Dietetics, integrated care home pharmacy team.
		5. Mental Health and Dementia Services.
		6. Dental Services.
		7. Opticians.
		8. Audiology.
		9. Podiatry.
		10. Continuing Healthcare team.
		11. Other GPs whose patients may be temporarily registered.
		12. Lambeth GP practices and other South East London Contractors as appropriate for the collaborative delivery of SEL primary care strategy.
		13. Local pharmacists.
		14. Urgent Care Centres.
		15. Local Authorities including Public Health and Social Services.
		16. HealthWatch Lambeth.
		17. Lambeth Third Sector Enterprise and local voluntary sector organisations as appropriate, including Advocacy.
		18. NHS 111.
		19. Diabetic Eye Screening Programme.
		20. Cancer screening programmes.
		21. Out of Hours GP services.
		22. Social Care Commissioners.
	4. There is a significant interdependence between the quality of care provided by Nursing/Older people Homes and that provided by the Contractor. The Commissioner, together with London Borough of Lambeth commissioners, will lead the development of Standard Operating Procedures for working with Nursing/Older people Homes that will cover all aspects of care that require a united integrated approach between Nursing/Older people Homes and the Contractor. This will include standard operating procedures on EoL care, falls prevention, serious incident management, wound management, dementia care and medicines optimisation. The Contractor is required to play an active role in developing the framework/ways of neighbourhood working. It is expected that the Framework will be developed during Year 1 of the contract and embedded by the end of Year 2.
	5. The Contractor shall, together with the Commissioner:
		1. Establish good information flows to/from pathology and diagnostic Contractors and NHS and non-NHS healthcare professionals.
		2. Foster good working relationships and gain mutual understanding of systems, policies and procedures with key local stakeholders.
		3. Establish a directory of information regarding local resources and foster a good understanding of the local patient care pathways to promote effective referrals; and
		4. Utilise specialist services (for example substance misuse, minor surgery, dermatology, NHS dentistry) tissue viability, continence and stoma care from central primary care locations and other services at local locations to avoid duplication of services, promote economies of scale, and bring practices together to plan and implement common aims for the benefit of those practices and their patients.
	6. The Contractor shall set up a robust system to share information and work closely with the Continuing Healthcare team and as relevant the Social Work Team who may be undertaking reviews for placements. Where it is clinically appropriate to do so, the Contractor shall make applications for continuing healthcare assessments.
	7. The Contractor shall be required to collaborate with the Commissioner in the following areas:
		1. structures – to ensure that links are maintained with key structures within the Commissioner and local health economy, particularly with forums dealing with Patient and Public Involvement (an NHS defined term) which is an initiative to involve patients and the public in the planning of services.
		2. process – to ensure that similar policies and protocols are in place between the Contractor and Commissioner (e.g. clinical policies, workforce planning including training opportunities and structured secondment programmes subject to agreement by the Commissioner and Department of Health).
	8. The Contractor will, as requested by the ICB, nominate representatives for key planning forums such as the Integrated Care System Board and sub- committees thereof, and the Lambeth Together Ageing Well Steering Group and any associated care home workstreams and ensure that service plans align to the strategic plans of the Commissioner and local authorities.
	9. The Contractor shall discuss and develop policies and procedures with the Commissioner to ensure there is compatibility with local policies and procedures, including clinical and non-clinical issues.
	10. Please note in Lambeth we are delivering the ‘Our Healthier South East London’ strategy. This strategy was first established in 2013 by local health commissioners to promote and develop more integrated, out-of-hospital and preventative care. We have subsequently established various transformation programmes and groups to secure patient, public and clinical involvement.
	11. Lambeth also has an Integrated Care Network (ICN) model as part of its Lambeth Together Alliance (multispecialty community service). This is a model of care that brings together a range of health and care services to work in a more joined up way to provide care for patients. This model enables services to be more responsive to the needs of patients and is focused on preventing ill health and proactively managing of patients with complex or long-term health conditions. The contractor will be expected to participate in this, and any other collaborative work with partners.
8. **Practitioner Skill Mix/Continuity**
	1. The Contractor shall:
	2. Notify the Commissioner about any planned material changes to the skill mix of Clinical Staff at the GP Practice.
	3. Keep the Commissioner informed of any changes in the permanently employed GPs, nurse practitioners or Practice Pharmacists.
	4. Take all reasonable steps to keep the use of locum GPs nurses or pharmacists to a minimum. 19% which is 10 weeks out of 52 allowing for 6 weeks annual leave, and 4 weeks sickness. This was based on the document Code of Practice in the Appointment and employment of HCHS Locum Doctors August 1997. The use of locums is never a matter of routine but is always justified in the light of service need with reference to quality assurance and standards and to risk management. So, we have said justification is for covering sickness and annual leave.
9. **Mental Capacity Act 2005, Informed Consent and Do Not Attempt Resuscitation (DNAR) Notices**
	1. The Contractor will comply with the Mental Capacity Act 2005 and its underpinning principles and have due regard to its associated Codes of Practice.
		1. The five principles of the Mental Capacity Act are:
			1. Principle 1: A person must be assumed to have capacity unless it is established that he lacks capacity.
			2. Principle 2: A person is not to be treated as unable to decide unless all practicable steps to help him to do so have been taken without success.
			3. Principle 3: A person is not to be treated as unable to decide merely because he makes an unwise decision.
			4. Principle 4: An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
			5. Principle 5: Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.
		2. The Contractor will ensure that, where appropriate, Mental Capacity Assessments are recorded and/or evidenced prior to any prescribed treatment being undertaken.
		3. The Contractor will co-operate with, take part in and/or provide evidence to Best Interest Meetings involving care and treatment in relation to patients in the scope of this contract.
	2. Do Not Attempt Resuscitation (DNAR) Notices should be discussed with patients, family and Next of Kin and documented appropriately.
	3. The contractor should comply with the DNAR guidance developed by the Lambeth End of Life Care Strategy Group. The guidance is in line with and based on national good practice and is recommended to be adopted as best practice by primary care and community health professionals in Lambeth caring for patients at the EoL.
	4. The Contractor shall comply with NHS requirements in relation to obtaining informed consent from each patient as notified to the Contractor by the Commissioner from time to time prior to commencing treatment including the following (as amended from time to time). The following publications and guidance are not an exhaustive list:
		1. [Department of Health Reference Guide to consent for](https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition) [examination or treatment (2nd Edition 2009)](https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition) (which reflects the Mental Capacity Act 2005):This document updates that issued in 2001 and provides a guide to the legal framework that all health professionals need to take account of in obtaining valid consent for any examination, treatment or care that they propose to undertake.
		2. [Consent: Patients and doctors making decisions together (GMC 2020):](https://www.gmc-uk.org/-/media/documents/consent---english-0617_pdf-48903482.pdf)This guidance expands on the guidance in Good Medical Practice, which requires doctors to be satisfied that they have consent from a patient, or other valid authority, before undertaking any examination or investigation, providing treatment, or involving patients in teaching and research.
		3. [Decisions relating to Cardiopulmonary Resuscitation (3rd edition](https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/)

 [- 1st revision)](https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/): The British Medical Association (BMA), the Resuscitation Council (UK), and the Royal College of Nursing (RCN) have issued updated guidance regarding anticipatory decisions about whether to attempt resuscitation in a person when their heart stops or they stop breathing. This latest 2016 revision of guidance is in response to public and professional debate about CPR decisions, and to recent statutory changes and legal judgments. The key ethical and legal principles that should inform all CPR decisions remain, but even greater emphasis has been placed on ensuring high-quality timely communication, decision-making and recording in relation to decisions about CPR.

1. **Power of Attorney**
	1. The Contractor shall establish where there is provision for ‘Lasting Power of Attorney’ with regards to Health and Welfare for their registered patients and understand who holds the Power of Attorney. This is especially important where patients are at the end of life and where management decisions are required.
2. **Safeguarding**
	1. The Contractor shall ensure that all Contractor Staff have:
		1. without prejudice to the provisions of Part 4 of Schedule 2 (*Staffing and Registration*), relevant professional registrations and an enhanced Disclosure and Barring Service checks.
		2. undertaken relevant protection training in line with general practice guidance.
		3. have ‘protected time’ for clinical and child protection supervision and know who to contact for advice on child protection matters; The Contractor shall work in partnership with key agencies in accordance with the guidance Working Together to Safeguard Children 2010, and subsequent revisions. The Contractor shall also act in accordance with the Commissioner and SEL ICB's child protection and safeguarding policies and standards and the London child protection procedures; and
		4. notwithstanding the generality of the above, the Contractor shall ensure that its Contractor Staff always act in accordance with the guidance provided by the Commissioner.
3. **Adults at Risk**
	1. The Contractor shall:
		1. ensure that all Contractor Staff have undertaken relevant safeguarding adult training, including mental capacity/ Deprivation of Liberty Safeguards (DoLs) and prevention awareness.
		2. ensure that all vulnerable adults are assessed for any risk of harm, neglect or abuse in line with Protecting Adults at Risk: London multi-agency policy and procedures to safeguard adults from abuse (2011) and act in accordance with the SEL ICB’s safeguarding standards. Provide the Services to vulnerable adults who attend the Urgent Care Centre Premises in accordance with the standards and responsibilities contained in the National Service Frameworks; Protection of Vulnerable Adults Scheme 2004 as may be amended from time to time as well as any further protocols that may be notified to the Contractor by the Commissioner from time to time.
		3. ensure that Clinical Staff who manage and treat vulnerable adults adhere to mandatory training as set out in local and national guidelines.
		4. work with the Director of Quality and Governance whose role will include oversight of safeguarding adult’s functions.
		5. work in partnership with the Local Borough of Lambeth and other key statutory and voluntary agencies involved in safeguarding vulnerable adults, for example, attending strategy meetings and case conferences as and when required; and
		6. ensure that clinical staff complete Level 3 training on an annual basis (training can be accessed via online platforms.
		7. Reporting via DATIX
4. **Clinical Governance & Quality Assurance** **Patient Safety Incident Response (PSIRF)**
	1. Please refer to the SEL ICB Quality Assurance Framework for Primary Care Contractors which references the minimum quality requirements that Lambeth expects the Contractor to meet. The Quality Assurance Framework is in line with the standards set out in the standard APMS contract.
	2. The Contractor shall:
		1. show a commitment to achieve the highest banding across the range of indicators on the NHS England Assurance Framework and/or any future quality scorecard by preparing and implementing suitable action plans until the standard is achieved.
		2. comply with any NHS England (London Region) Quality Standards that may be introduced during the term of the contract, subject to the agreement of additional funding should it be reasonably required.
		3. operate an effective, comprehensive, System of Clinical Governance with clear channels of accountability, supervision and reporting, and effective systems to reduce the risk of clinical system failure.
		4. have medical leadership in place.
		5. nominate a person who will have responsibility for ensuring the effective operation of the System of Clinical Governance and who is accountable for any activity carried out on a Patient.
		6. continuously monitor and report on clinical performance and evaluate Serious Incidents, near misses and complaints arising from any activity including ‘learning the lessons’ and provide the Commissioner with the records of such to assist the Commissioner in assessing whether standards are being.
		7. use appropriate formal methods such as root cause analysis for Serious Incidents, near misses and complaints.
		8. have in place a system for collecting data on Serious Incidents, near misses and complaints in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements. Furthermore, the Contractor shall have in place a system for adopting such changes into practice and processes going forward.
		9. operate robust auditing of clinical care against clinical standards and in line with CQC essential standards.
		10. comply with the Commissioner’s governance requirements and inspections and make available, on reasonable notice to the Commissioner, all Contractor records (including permitting the Commissioner to take copies) relating to Contractor clinical governance to enable the Commissioner to audit and verify the clinical governance standards of the Contractor.
		11. where appropriate, fully implement any recommendations following Commissioner clinical governance inspections within three (3) months of notification by the Commissioner of the recommendations.
		12. provide the Commissioner with an annual report and service improvement plan on a template to be provided by the Commissioner.
		13. participate in all quality and clinical governance initiatives agreed between the Commissioner and its other GP Practices.
	3. Patient Safety Incident Response Framework (PSIRF) - The Contractor shall:
		1. The contractor must agree with its ICB a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan, as described in line with NHS England Framework. [Patient Safety Incident Response Framework](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/). These must be published on the contractor’s website.
	4. Under PSIRF, the contractor must:
		1. engage compassionately with affected patients, carers and staff following any patient safety incident.
		2. respond in a proportionate way to such incidents, undertaking investigations where appropriate; and
		3. ensure that improvements to services are implemented following responses to incidents.
5. **Information Governance and Security**
	1. In addition to the Information Governance requirements set out in the Contract, Contractors are required to comply with the Information Governance requirements set out in new APMS template
6. **Clinical Safety and Medical Emergencies**
	1. The Contractor shall:
		1. ensure that all Contractor Staff have and maintain basic life support certification with competence in defibrillation and ensure that all the Contractor Staff comply with the UK Resuscitation Council guidelines on basic life support and the use of automated external defibrillators.
		2. ensure the availability of sufficient numbers of the Contractor Staff with appropriate skill, training and competency and who are able and available to recognise, diagnose, always treat and manage Patients with urgent conditions when the Service is open.
		3. possess the equipment and in-date emergency drugs including oxygen to treat life-threatening conditions such as anaphylaxis, meningococcal disease, suspected myocardial infarction, status asthmaticus and status epilepticus.
		4. pass all life-threatening conditions to the ambulance service as soon as practicable by dialling 999 and requesting the ambulance service.
		5. work with the Nursing/Older people Homes to put in place and agree appropriate pathways and protocols to ensure that the Patients can be transferred to the Emergency Department or Urgent Care Centre if required; and
		6. adhere to any national or local guidelines relating to clinical safety and medical emergencies in primary care as amended from time to time.
7. **Good Clinical Practice**
	1. Without prejudice to the quality standards of this Contract, the Contractor shall perform the Services in accordance with the following requirements as amended from time to time:
		1. Care Quality Commission Essential Standards in force from time to time during the term of this Contract.
		2. the “excellent GP” according to Good Medical Practice for General Practitioners (RCGP 2013).
		3. any relevant Medicines and Healthcare products Regulatory Agency (MHRA) guidance, technical standards, and alert notices.
		4. the highest level of clinical standards that can be derived from the standards and regulations referred to in Schedule 2; and
		5. the General Medical Council guidance on Good Medical Practice (2013).
	2. The Contractor shall ensure that clinical meetings are convened for all clinicians working in the practice a minimum of once each calendar month.
	3. The Contractor is required to achieve registration with the Care Quality Commission (‘CQC’). The Contractor shall ensure that any variation to any current registration is undertaken in a timely manner, or if the Contractor is not currently registered that they provide a comprehensive action plan for achieving registration in their mobilisation plan.
8. **Equipment**
	1. The Contractor shall provide all medical and surgical equipment, medical supplies including medicines, drugs, instruments, appliances, and materials necessary for the delivery of services under this Agreement, which shall be adequate, functional and effective.
9. **Infection Prevention and Control**
	1. Without prejudice to clause 12 of this Contract, the Contractor shall have in place arrangements that meet the standards outlined in the [Overview | Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE](https://www.nice.org.uk/guidance/cg139), and the NHS England Standard Operating Procedure Infection Prevention & Control Audit requirements.
	2. Nursing/Older people Homes are responsible for maintaining a safe environment for their residents under Care Quality Commission Regulations. See in particular Regulation 12 (Safe Care and Treatment) and Regulation 15 (Premises and Equipment). The Contractor is required to report any concerns arising from the Nursing Home environment that is impacting on the safe delivery of Services to the Commissioner.
	3. The Contractor will follow guidance on the management of patients in the community with clostridium difficile infection as outlined in the guidance, *South London Guidelines for Management of Clostridium difficile infection in the Community*, as set out in the embedded document within Appendix 1 (part 4) of Schedule 2.
10. **New primary care developments**
	1. The Contractor shall cooperate with the Commissioner to implement all developments arising from the Health and Social Care Act 2012 or any new legislation including, without limitation, implementation of:
		1. shared decision making with patients.
		2. personalised care for patients (including self-care, expert Patient programs and self-monitoring).
		3. improving healthcare outcomes through outcome-based quality standards).
		4. empowering professionals and Contractors; and
		5. Integrated Care Network principles and development.
11. **Risk Management**
	1. The Contractor will need to ensure it covers risk management in its’ Business Continuity and Emergency Plan.
	2. The Contractor shall:
		1. Operate mechanisms for assessing & managing clinical and general business risk including maintenance of a suitable risk register that is reviewed, as a minimum by the business owners monthly.
		2. Prepare disaster recovery, contingency and business continuity plans that should be available for inspection by the Commissioner at any time.
		3. Keep the Commissioner fully informed about any significant risks that have been identified that could impact on the performance of the contract
		4. Notify the Commissioner of the person responsible for risk management within the Contractors organisation.

1. **Patient Records**
	1. The Contractor shall at its own cost retain and maintain all the clinical records in accordance with:
		1. Good Clinical Practice; and
		2. this Schedule 2.
	2. The Contractor shall at its own cost retain and maintain all the paper based clinical records in chronological order and in a form that is capable of audit. Records should be stored either in an electronic health record or paper format which should be digitalised in line with current NHS England guidelines. All clinical records are maintained at its own cost.
	3. The Contractor shall undertake a programme of audit of individual clinicians’ electronic medical records on at least an annual basis for all clinicians engaged to work at the practice on the contractor’s behalf. To review but not limited to the following Medication prescribing, record keeping, quality assurance and incidents.
2. **Contractor Reporting**
	1. The Contractor shall supply the following reports to the Commissioner:
		1. Quality Report, which shall provide information on incidents, complaints and other quality measures, on a quarterly basis in line with agreed reporting timetables.
		2. KPI Report shall provide contract performance information in accordance with the reporting timetable (reporting deadlines to be agreed with the Commissioner upon contract mobilisation). The KPI Report will provide details of activity against plan and exceptions.
		3. Minimum Data Set Report - which shall include data conforming to the Nursing/Older people Homes Minimum Dataset. This should be submitted in accordance with the reporting timetable.
		4. Safeguarding Report:This should be submitted in accordance with the reporting timetable.
		5. National data set reporting. (This shall include full compliance by the Contractor with all the requirements necessary for the operation of CQRS and GPES).
		6. The Contractor shall supply the following activity reports as per the standard APMS contract (Schedule 5, Clause 10).
		7. The Contractor shall ensure that all data is coded appropriately.
		8. The Commissioner requires that an agreed template is developed by the Contractor to report safeguarding issues with three (3) months after the date of this Agreement.
		9. The Contractor shall also supply information to the Commissioner as reasonably required for the purpose of monitoring equality of access to the Services and to fulfil the Commissioner’s obligations under the Law. Data required may include gender, age, ethnicity, sexual orientation, religion or belief and disability characteristics of the patients.
		10. The Contractor is required to supply additional information (where this is not available in any regular submissions) to support service reviews and analysis as and when requested by the Commissioner.
		11. The Commissioner reserves the right to carry out data audits announced or on an ad- hoc basis (subject always to compliance with all confidentiality and data protection provisions in this Agreement).
		12. Where after any review or audit, it comes to the attention of the Commissioner that the information provided to the Commissioner by the Contractor under this Agreement was, when given, untrue, materially incomplete and/or inaccurate, the Commissioner may:
			1. request an urgent review meeting with the Contractor (such meeting to be held within 5 Business Days after request by the Commissioner); and/ or
			2. issue a breach of contract notice or other sanction on the contract as is reasonable and in line with APMS contract management rules.
		13. There may be occasions when the Commissioner requests additional information outside of that set out in this Schedule. The Commissioner shall indicate the purpose and priority of information requested and will agree the delivery of any such requests with the Contractor, provided always that the Contractor shall use reasonable endeavours to provide such information to the extent it can be provided without incurring additional costs.
		14. The Contractor shall, within 48 hours inform the Commissioner by email if it fails to meet the deadlines for the Quarterly reports.
3. **Outcome Reporting**
	1. To be covered in Schedule 6.
4. **Contractor Records**
	1. The Contractor shall during the term of this Contract and for a period of six (6) years thereafter, maintain at its own cost such records relating to the provision of the Services, the calculation of the Charges and/or the performance by the Contractor of its obligations under this Contract as the Commissioner may reasonably require in any form (the “Records”), including information relating to:
	2. The Contractor shall, subject always to the provisions of relevant legislation and Directions:
		1. on request produce the Records for inspection by the Commissioner or, on receipt of reasonable notice, allow or procure for the Commissioner and/or its authorised representatives access to any premises where any Records are stored for the purposes of inspecting and/or taking copies of and extracts from Records free of charge and for the purposes of carrying out an audit of the Contractor’s compliance with this Contract, including all activities of the Contractor, the Charges and the performance, and the security and integrity of the Contractor in providing the Services under this Contract.
		2. preserve the integrity of the Records in the possession or control of the Contractor and Contractor Staff and all data which is used in, or generated because of, providing the Services.
		3. prevent any corruption or loss of the Records, including keeping a back-up copy; and
		4. provide any assistance reasonably requested by the Commissioner to interpret or understand any Records.
		5. take reasonable measures to ensure that the Records are updated using appropriate Read codes, using where applicable those Read codes required by the Commissioner and / or as required by the Technical Requirements for GMS Contract Changes.
		6. The Contractor shall ensure that during any Records inspection the Commissioner and/or its authorised representatives receive all reasonable assistance and access to all relevant Contractor staff, premises, systems, data and other information and records relating to this Contract (whether manual or electronic).
5. **Applicable National Standards**
	1. The Contractor shall comply with all best practice and NICE Quality standards including, but not limited to:
		1. Quality Care for Older People with Urgent & Emergency Care Needs, 2012.
		2. NICE Quality Standards on End-of-Life Care. [Overview | End of life care for adults](https://www.nice.org.uk/guidance/qs13)
		3. NICE Quality standards on LTC including Diabetes. [Overview | Social care for older people with multiple long-term conditions](https://www.nice.org.uk/guidance/qs132)
		4. NICE Quality standards on Dementia. [NICE quality standards on Dementia](https://www.nice.org.uk/search?q=NICE%20quality%20standards%20on%20Dementia)
		5. [NICE guidance for occupational therapy, and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care](https://www.google.co.uk/search?q=NICE+guidance+for+occupational+therapy%2C+and+physical+activity+interventions+to+promote+the+mental+wellbeing+of+older+people+in+primary+care+and+residential+care&sca_esv=41165fec71bc817d&sxsrf=ADLYWIIm5Oux23dN-GfJsKQS6aKWld4L2Q%3A1732710745956&source=hp&ei=WRFHZ7vxN6PNhbIP1-CiiQQ&iflsig=AL9hbdgAAAAAZ0cfacIi_lVnc7RsxvKCmJ3zv26aghPQ&ved=0ahUKEwj7gYnEwvyJAxWjZkEAHVewKEEQ4dUDCBk&uact=5&oq=NICE+guidance+for+occupational+therapy%2C+and+physical+activity+interventions+to+promote+the+mental+wellbeing+of+older+people+in+primary+care+and+residential+care&gs_lp=Egdnd3Mtd2l6IqABTklDRSBndWlkYW5jZSBmb3Igb2NjdXBhdGlvbmFsIHRoZXJhcHksIGFuZCBwaHlzaWNhbCBhY3Rpdml0eSBpbnRlcnZlbnRpb25zIHRvIHByb21vdGUgdGhlIG1lbnRhbCB3ZWxsYmVpbmcgb2Ygb2xkZXIgcGVvcGxlIGluIHByaW1hcnkgY2FyZSBhbmQgcmVzaWRlbnRpYWwgY2FyZTIFECEYoAEyBRAhGKABMgUQIRigATIFECEYoAFIxIADUI4GWNf-AnALeACQAQCYAZABoAHDJaoBBDUzLji4AQPIAQD4AQGYAkigAr0nqAIKwgIHECMYJxjqAsICEBAuGMcBGCcY6gIYjgUYrwHCAgoQIxiABBgnGIoFwgIREAAYgAQYkQIYsQMYgwEYigXCAgsQABiABBiRAhiKBcICERAuGIAEGLEDGNEDGIMBGMcBwgILEAAYgAQYsQMYgwHCAgQQIxgnwgIOEAAYgAQYsQMYgwEYigXCAgUQLhiABMICCBAuGIAEGLEDwgILEC4YgAQYsQMY1ALCAg4QLhiABBixAxiDARiKBcICDhAuGIAEGLEDGNEDGMcBwgIIEAAYgAQYsQPCAgsQLhiABBixAxiDAcICCxAAGIAEGJIDGIoFwgIIEAAYgAQYyQPCAgUQABiABMICBxAAGIAEGArCAgYQABgWGB7CAgsQABiABBiGAxiKBcICCBAAGIAEGKIEwgIEECEYFcICBRAhGJ8FwgIHECEYoAEYCpgDDpIHBTYyLjEwoAfb6AM&sclient=gws-wiz)
		6. [Community engagement to improve health](http://guidance.nice.org.uk/PH9). NICE public health guidance 9 (2008).
		7. [Promoting and creating built or natural environments that](http://guidance.nice.org.uk/PH8) [encourage and support physical activity.](http://guidance.nice.org.uk/PH8) NICE public health guidance 8 (2008).
		8. [Overview | Behaviour change: general approaches | Guidance | NICE](https://www.nice.org.uk/guidance/ph6) NICE public health guidance 6 (2007).
		9. Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (2007, amended) replaced by [NICE clinical guideline 90](http://www.nice.org.uk/CG90).
		10. [Dementia: supporting people with dementia and their careers in](http://www.nice.org.uk/CG42) [health and social care.](http://www.nice.org.uk/CG42) NICE clinical guideline 42 (2006).
		11. [Obesity: guidance on the prevention, identification, assessment](http://www.nice.org.uk/CG43) [and management of overweight and obesity in adults and](http://www.nice.org.uk/CG43) [children.](http://www.nice.org.uk/CG43) NICE clinical guideline 43 (2006); and
		12. [Overview | Falls in older people: assessing risk and prevention | Guidance | NICE](https://www.nice.org.uk/guidance/cg161) clinical guideline (CG161) (2013).
	2. The Contractor is required to meet these standards and report against them on a regular basis or as set out above.
6. **Employment, Registration, Permits, and Vetting**
	1. The Contractor shall comply with:
	2. the relevant human resources provisions in the NHS Plan applicable to the Contractor and, where not directly applicable to the Contractor, the Contractor shall comply with the principles and spirit of the relevant human resources provisions in the NHS Plan.
	3. the following policies and guidance as amended, updated, or replaced from time to time:
		1. NHS Employment Check Standards, March 2008 (revised September 2012 or from time to time thereafter).
		2. the Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) (the “Code of Practice”).
		3. Standards for Better Health (available on <http://www.dh.gov.uk/> [www.dh.gov.uk](http://www.dh.gov.uk/) and [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)).
		4. The Criminal Records Bureau Code of Practice for Registered Persons and other recipients of Disclosure Information published by the Home Office under the Police Act 1997 (revised April 2009) (“Code of Practice on Disclosure”).
		5. the DH’s guidance on the employment or engagement of bank staff, if any.
		6. Any guidance and/or checks required by the Independent Safeguarding Authority (or success organisation) or any other checks which are to be undertaken in accordance with current and future national guidelines and policies.
		7. All guidance issued by the Care Quality Commission including the guidance entitled “Compliance: Essential Standards of Quality and Safety (March 2010)” and any other guidance issued by the Care Quality Commission from time to time.
		8. Cabinet Office Statement entitled “Principles of Good Employment Practice (December 2010);”
		9. The Cabinet Office Statement (as defined in Schedule 1 to this Contract); and
		10. all relevant employment legislation and codes of practice applicable in the UK.
	4. The Contractor shall ensure that all Contractor Staff:
		1. have all necessary permits and/or entitlements to work in England in relation to the provision of the Services.
		2. can communicate in English at a level appropriate to their role so that they are able to communicate effectively with patients and other persons in relation to the Services, including (where relevant) IELTS/PLAB tests as detailed in the Code of Practice for NHS Employers as amended from time to time in relation to the international recruitment of Health Care Professionals.
		3. are registered with all appropriate regulatory bodies including without limitation the following:
			1. for medical Contractor Staff, the General Medical Council (GMC).
			2. for nursing Contractor Staff, the Nursing and Midwifery Council; and
			3. for Pharmacy Contractor Staff, the General Pharmaceutical Council and
			4. for Contractor Staff who are other Health Care Professionals (including Allied Health Professionals and Health Care Scientists (where appropriate)), the Health Professions Council.
		4. The Contractor shall ensure that:
			1. medical Contractor Staff performing specialist procedures, are suitably qualified, competent and experienced and are registered in the GMC Specialist Register in respect of the specialty in which they perform specialist procedures.
		5. GPs are:
			1. registered with the GMC; and
			2. hold appropriate certificates confirming their eligibility to work in general practice.
		6. nursing Contractor Staff are registered on the Nursing and Midwifery and Health Professional Council Register and, if they are to prescribe medicine or medical devices, that the corresponding entry in the register indicates they hold a prescribing qualification.
		7. Pharmacy Contractor Staff are registered on the General Pharmaceutical Council Register and, if they are to prescribe medicines or medical devices, that the corresponding entry in the register indicates they hold a prescribing qualification; and
		8. appropriate arrangements are in place for re-registering and monitoring subsequent re-registration for Health Care Professionals as appropriate.

1. **Workforce Strategy**
	1. The Contractor shall ensure that:
		1. its staffing arrangements (as may be amended or updated from time to time by prior written agreement between the parties) are sufficient to mobilise and manage the provision of the Services during any change period and throughout the term of this Contract considering estimated growth and Patient numbers (where appropriate); and
		2. there are, always, sufficient numbers of Contractor Staff engaged in the provision of the Services with the requisite level of skill and experience to cover Contractor Staff absences (for example, holidays and sickness) and to cope with planned or unplanned increases in workload.
		3. Subject to the Contractor’s obligations to comply with Clause 67 of the main body of this Contract, the Contractor shall (and shall procure that any of its sub- Contractors shall), allow the Commissioner full access, on an open book basis, to any information or data in respect of all employees or other persons employed or engaged in the provision of the Services, or in relation to any recruitment or any other matter concerning this Contract, which the Commissioner considers relevant.
		4. implement workforce management information systems which can deliver any internal and external monitoring and workforce reporting requirements and of monitoring compliance with the Working Time Regulations 1998.
		5. provide timely and accurate workforce reports including, if required, input into the annual NHS workforce census and the NHS vacancy surveys; and
		6. if requested by the Commissioner, use its best endeavours to procure that Contractor Staff participate in the annual NHS staff survey.
		7. The Contractor shall have an operational management organisation structure chart which demonstrates the key operational management roles and responsibilities, reporting relationships and accountabilities. The Contractor shall inform the Commissioner within five (5) working days if they make any material changes to this chart.
		8. The Contractor shall have a designated role responsible for Staff management, leadership and practice management, known as “the Practice Manager”.

1. **Contractor Staff Recruitment**
	1. The Contractor shall ensure that:
		1. any recruitment agency partners used for recruitment or engagement in the UK are compliant with NHS Employers Code of Practice for NHS Employers as amended from time to time.
		2. in employing or otherwise engaging Clinical Staff it complies with the agreed person specifications as minimum requirements in terms of qualifications, knowledge, skills and experience.
		3. all Clinical Staff are covered by appropriate indemnity insurance.
		4. interviews of Clinical Staff take place with a suitably qualified interview panel, that proper references are sought and that professional qualifications are verified; and
		5. its recruitment policy, strategies and supporting processes must promote equal opportunity and anti-discriminatory practice to enable them to attract and retain a high quality, competent workforce in adequate numbers, for the duration of the Contract.
2. **Appointment of Contractor Staff**
	1. The Contractor shall:
		1. comply with the rules and requirements regarding employment checks as set out in the NHS Employment Check Standards,

 March 2008 (as amended in September 2012 and as may be further amended from time to time).

* + 1. comply with the Cabinet Office Statement entitled “Principles of Good Employment Practice (December 2010);”
		2. ensure that all Contractor Staff receive Training, supervision, necessary induction and are competent and fit for purpose to ensure the proper performance of the Services in accordance with this Contract and any NHS Requirements of which the Contractor is notified from time to time.
		3. ensure that it will not use any individual for the performance of the Services in respect of whom an Alert Letter has been issued as amended by the Secretary of State’s guidance of November 2006 (at Gateway 7147).
		4. ensure that it is (and at all times during the term of this Contract shall be) a Registered Person within the meaning of the Police Act 1997 and the Police Act 1997 (Criminal Records)(Registrations) Regulations 2006 and an Umbrella Organisation within the meaning of the Code of Practice on Disclosure (for the purposes of applications made in relation to any sub-contractors of the Contractor) and that it complies at all times with the provisions of the Rehabilitation of Offenders Act 1974, the Police Act 1997, the Police Act 1997 (Criminal Records)(Registrations) Regulations 2006 and the Code of Practice on Disclosure as amended from time to time;
		5. ensure that it shall not (and shall procure that its sub-Contractors shall not) employ or engage any person in relation to the Services unless the highest form of available Disclosure is obtained by the Contractor as follows:
			1. if such person would be employed or engaged in an ERC Position or CRC Position, unless and until such person provides the Contractor with Enhanced Disclosure and the relevant Standard Disclosure as appropriate; and
			2. unless and until such person to whom paragraph 4.1(f)(i) would not apply provides the Contractor with Standard Disclosure and, the Contractor acknowledges that , if it is not possible to obtain Enhanced Disclosure from the Disclosure and Barring Service (DBS) in respect of such person, unless and until such person provides the Contractor with a copy of the information supplied by the relevant Data Controller in response to a subject access request by such person in respect of Personal Data held on the Police National Computer in relation to that person.
		6. ensure that it shall not (and shall procure that its sub-contractors shall not) employ or engage any Overseas Person in relation to the Services unless and until the Contractor and/or any sub- contractor of the Contractor and/or the Overseas Person (in each relevant country) provide(s) Overseas Disclosure in respect of:
			1. each country outside the United Kingdom of which the Overseas Person is a citizen.
			2. each country outside the United Kingdom of which the Overseas Person holds a relevant professional qualification; and
			3. each country outside the United Kingdom of which the Overseas Person has worked.
		7. save in circumstances in which it is not possible for the Contractor and/or any sub- contractor of the Contractor and/or the Overseas Person using best endeavours to obtain Overseas Disclosure in or in relation to a particular country. The Contractor acknowledges that, Overseas Persons shall also be subject to the DBS provisions set out in paragraph 4.1(f) and the Contractor shall obtain or procure the obtaining of by any sub- Contractor of the Contractor /or the Overseas Person, as appropriate, (in respect of any country where Overseas Disclosure is available) the highest form of available Overseas Disclosure. In circumstances in which it is not possible in respect of an Overseas Person for the Contractor and/or any sub-contractor of the Contractor and/or the Overseas Person using best endeavours to obtain Overseas Disclosure in relation to a particular overseas country, the Contractor shall (and shall procure that any sub- contractor of the Contractor shall) not employ or engage any such person in relation to the Services by the Contractor or any sub- Contractor of the Contractor, without the Commissioner’s prior written consent
		8. procure that no person (which shall for the purposes of this paragraph include any Overseas Person) who discloses any Convictions, or in respect of whom any other matter is revealed following Disclosure or Overseas Disclosure, in either case, of which the Contractor is aware or ought to be aware, is employed or engaged in the provision of the Services or any activity related to or connected with the provision of the Services by the Contractor or any sub- Contractor of the Contractor, without the Commissioner’s prior written consent; and
		9. ensure that the Commissioner is kept informed at all times of any person employed or engaged by the Contractor or any of its sub-contractor s in relation to the Services who, subsequent to his/her commencement of such employment or engagement, receives a Conviction of which the Contractor or any sub- contractor of the Contractor becomes aware or whose previous Convictions become known to the Contractor or any sub- contractor of the Contractor.
		10. The Contractor shall implement an appropriate competency assessment process that includes competency assessment tools, to assess the practical competency of all Clinical Staff on recruitment. The Commissioner reserves the right to introduce specific appropriate competency assessment tools at any time during this Contract and require the Contractor to include them in its recruitment and induction process.
		11. The Contractor must implement a comprehensive induction programme and shall ensure that every member of Contractor Staff is trained and assessed as competent during induction to:
			1. administer basic life support; and
			2. use automated external defibrillators.

* + 1. The Contractor shall have in place contingency arrangements to ensure adequate, available cover in the case of any:
			1. planned or unplanned increases in workload.
			2. Contractor Staff absences; and
			3. medical emergencies.
		2. The Contractor shall make available to all Contractor Staff as soon as reasonably practicable, a staff handbook that will include details of its:
			1. employment terms and conditions.
			2. HR policies; and
			3. performance management policy.
		3. The Contractor shall manage the Contractor Staff based on principles of equal opportunity, anti-discriminatory practice, equity and fairness, communication and involvement and confidentiality.
		4. The Contractor shall have a comprehensive health and safety policy that complies with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999). The Contractor shall ensure that the health and safety policy includes:
			1. the written statement (as required by section 2(3) of the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, if applicable) (or EU member state equivalent) of the organisation.
			2. the name and status of the person responsible for the implementation of the organisation’s health and safety policy.
			3. a description of how the Contractor will manage its obligations in respect of health and safety at work; and
			4. a description of how health and safety responsibilities are allocated within the organisation.

1. **Terms and Conditions and Employee Relations**
	1. The Contractor shall: Ensure that all monies, salary, benefits, tax and national insurance contributions due to be paid to any Contractor Staff or the Inland Revenue, relating to the provision of Services by the Contractor, shall be paid up in full by the Contractor and the Contractor shall fully indemnify the Commissioner in respect of any losses incurred by the Commissioner as a result of the Contractor 's breach of this paragraph 5.1(a); and
	2. ensure that its human resources and workforce policies and procedures do not conflict with the aims and objectives of the HR strategy elements in the NHS Plan, adhere to best employment practice in the NHS and the “Agenda for Change” and “Pay Modernisation” initiatives.

1. **Staff Performance Management**
	1. The Contractor shall:
		1. put in place a performance management policy and suitable arrangements for handling concerns about the conduct and performance of all Contractor Staff.
		2. comply with the requirements of the regulatory bodies for revalidation and re-registration.
		3. put in place processes to ensure robust clinical governance and perform appropriate clinical audits for the continuing professional development of Contractor Staff needs following regular appraisals of Contractor Staff; and
		4. ensure that Contractor Staff are aware of the needs of those working in a health service environment, observe the highest standards of hygiene, customer care, courtesy and consideration, and keep confidential all confidential information and information relating to any Patient.
	2. The Contractor shall ensure that appropriate arrangements are in place for the supervision of all Clinical Staff. For GPs, this will include the conduct of peer reviews of each other’s performance once a month, to assess their own work and discuss clinical outcomes and specific cases of clinical importance for the team. The Contractor shall ensure that this process is conducted in line with good audit practice.

1. **Contractor Staff Training and Development**
	1. The Contractor shall:
		1. ensure that all Contractor Staff involved in treating Patients are appropriately trained and competent to carry out the roles required of them for the duration of this Contract.
		2. facilitate and provide access to the training and continuing professional development of Contractor Staff and ensure that all Contractor Staff receive such training, supervision and induction as is necessary to ensure the proper performance of the Services in accordance with this Contract.
		3. develop and implement a training plan for all Contractor Staff to ensure the safe and correct operation of all systems and

 equipment and adherence to processes and procedures to meet mandatory/statutory training requirements.

* + 1. implement a continuing professional development (CPD) plan for all Contractor Staff which will:
			1. promote a patient-centred approach, including the dignity of the Patient, carers, and relatives.
			2. ensure that all Clinical Staff involved in treating patients are appropriately skilled, trained, and competent to carry out the roles required of them for the duration of the Contract.
			3. ensure the safe, correct and up to date operation of all systems, processes, procedures, and equipment.
			4. respond to individual training needs arising from Contractor Staff performance appraisal and clinical supervision.
			5. respond to the individual professional development needs of Contractor Staff.
			6. support workforce strategies.
			7. comply with the provisions of Standards of Better Health and equal opportunities and anti-discriminatory employment legislation.
			8. meet the requirements of professional bodies for re-registration and revalidation; and
			9. ensure that clinical supervision for GPs includes the conduct of peer reviews of performance no less than once every month to discuss the work of the GP, clinical outcomes and specific cases of clinical importance to the team.
1. **Consequences of Termination**
	1. In addition to the requirements of clause 58-65, the Contractor shall:
		1. for a reasonable period both before and after the termination of this Contract, fully co-operate with the Commissioner and any successor providing services similar to the Services (or any part of them) in order to achieve a smooth transfer of the delivery of such services and to avoid any inconvenience or any risk to the health and safety of Patients and/or of employees of the Commissioner and/or members of the public, including continuing to provide the Services (which shall be paid for by the Commissioner in accordance with this Contract) until otherwise directed by the Commissioner; and
		2. fully co-operate with the Commissioner in the event that the Commissioner conducts a competition prior to the Expiry Date with a view to entering into a contract for the provision of services (which may or may not be the same as, or similar to, the Services or any of them) following the expiry of this Contract, including providing any information which the Commissioner may reasonably require to conduct the competition (such as information relating to the terms and conditions of employment or engagement of Contractor Staff and numbers and job descriptions of Contractor Staff involved), although the Contractor shall not be required to provide information which is commercially sensitive (i.e. information which would, if disclosed to a competitor of the Contractor, give that competitor a competitive advantage over the Contractor and thereby prejudice the business of the Contractor).
	2. The Contractor shall:
		1. ensure that it adheres to Data Protection Legislation, particularly in respect of personal information relating to individuals employed by the Contractor; and
		2. comply with all relevant Laws and Codes of Practice relating to employment in relation to all Contractor Staff.

1. **Equal Opportunities**
	1. The Contractor shall:
		1. not unlawfully discriminate against any person within the meaning of the Part Time Workers (Prevention of Less Favourable Treatment) Regulations 2000, the Fixed Term Employees (Prevention of Less Favourable Treatment) Regulations 2002 and the Equality Act 2010 including on the grounds of, without limitation, age, race, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.
		2. comply with all current equality legislation including, without limitation, the Equality Act 2010 and any other Law relating to discrimination in the provision of the Services, and, without limitation, any obligations contained within such legislation and Law to have due regard to the need to eliminate unlawful discrimination and harassment and to promote equality of opportunity in employment.
		3. adopt policies to comply with their statutory obligations under the Equality Act 2010 and any other Law relating to discrimination in the provision of the Services and confirm to the Commissioner details of such policies.
		4. take all necessary steps (and deliver to the Commissioner full details of the steps taken) to prevent recurrence of unlawful discrimination designated as such by any court or tribunal, or Commission for Racial Equality (“CRE”), the Equal Opportunities Commission (“EOC”), the Disability Rights Commission (“DRC”) or the Equality and Human Rights Commission (“EHRC”) or any successor body to the CRE, EOC, DRC or EHRC.
		5. comply with all Codes of Practice (as amended or replaced from time to time) issued by the CRE, the DRC, the EOC or the EHRC

 (or any successor organisations) for the elimination of discrimination and harassment and the promotion of equal opportunity in employment and provide such information as the Commissioner may reasonably request for the purposes of ascertaining compliance with this paragraph 9.1(e); and

* + 1. comply with any other requirements and instructions which the Commissioner reasonably imposes in connection with any statutory equality obligations imposed on the Commissioner at any time.

1. **Blood Borne Viruses**
	1. The Contractor shall:
		1. in respect of Contractor Staff (but excluding Exempt Staff) that are or may be engaged in Exposure Prone Procedures, comply with BBV Guidelines.
		2. ensure that all Contractor Staff are kept fully aware of their professional, Contractual and statutory obligations (as applicable to their specialty) to disclose, or seek testing for Blood Borne Viruses following any incident which carries a risk of infection or exposure to infection (including needlestick injuries), or which become known to staff members because of any medical examination or testing.
		3. ensure that occupational health services are available to support the Contractor in complying with the requirements in this paragraph 10.1.
		4. ensure the Contractor’s recruitment and health and safety policies include and are implemented to give effect to the requirements in this paragraph 10.1.
		5. comply with all circulars, instructions, directions, guidance, regulations, codes and/or requirements of the NHS and/or the Authority in respect of any Contractor Staff in connection with Blood Borne Viruses and Exposure Prone Procedures.
		6. ensure for each and every member of Exempt Staff prior to his or her engagement on Exposure Prone Procedures that the Contractor has received (subject to Law) written confirmation from the NHS Body that employs such person that the engagement of the relevant member of Exempt Staff on Exposure Prone Procedures does not or would not breach BBV Guidelines and ensure that the relevant employing NHS Body notifies the Contractor immediately if any member of Exempt Staff that is or may be engaged by the Contractor on Exposure Prone Procedures should or would be required under BBV Guidelines to cease to or not perform Exposure Prone Procedures. If the Contractor receives such notification, it shall if appropriate and in accordance with BBV Guidelines ensure that the member of Exempt Staff who is the subject of the notification ceases to or does not perform Exposure Prone Procedures.

1. **Testing**
	1. The Contractor must undertake testing of the IM&T Systems and any interfaces and inter-working systems, to guarantee compliance with all appropriate standards and to prove operational effectiveness.
	2. The Contractor must demonstrate that the IM&T System is fit for purpose and must make it available for testing by the Commissioner or its agents. The Contractor must obtain approval from the Commissioner in relation to its IM&T Systems prior to its use. If the Contractor cannot demonstrate compliance, the Commissioner reserves the right to require the Contractor to comply.

1. **Funding**
	1. IT equipment will be funded under the arrangements in place with SEL ICB ICT team and where/when required if needed approved by the locally Commissioner.

**Schedule 2**

## Service Specification

## – Part 2 Service Requirements

**Local Context**

This revised specification was developed to remove this duplication and update the service model to reflect the new PCN DES Enhanced Health in Care Homes (EHCH) Framework, improve alignment with the at-scale Federation offer, and thereby maintain or improve high quality care for residents as part of the new commissioning arrangements.

The Lambeth Together Neighbourhood & Wellbeing Delivery Alliance (NWDA) provides the overarching strategic context for work on care homes in Lambeth. The overall primary care offer to Nursing/Older people Homes should be viewed as a combination of this new EHCH PCN DES specification.

For Confirmation the Nursing and Older Homes to be covered under the service are as below:

* 1. British Home & Hospital for Incurables, Crown Lane, London SW16 3JB
	2. Collingwood Court Care Home, Nelsons Row, Clapham, London SW4 7JR
	3. Fairlie House, 2-6 Uffington Road, West Norwood, London, SE27 0RW
	4. Havelock Court Care Home, 6 Wynne Road, Stockwell, London, SW9 0BB
	5. Limetree Care Home, 8 Limetree Close, London, SW2 3EN
	6. Little Sisters of the Poor - St Peters Residence, St Peters Residence, 2A Meadow Road, London, SW8 1QH
	7. St Mary's Care Home, 3 Tooting Bec Gardens, London, SW16 1QY
	8. Uplands Care Home, 254 Leigham Court Road, London, SW16 2QH
	9. Windmill Lodge Care Home, 115 Lyham Road, Brixton, London, SW2 5PY
	10. Aashna House Residential Care Home, 2 Bates Crescent, Streatham Vale, London, SW16 5BP
	11. Joybrook, 86 Braxted Park, Streatham, London, SW16 3AU
1. **Key Objectives**
	1. Proactive Support to Nursing / Older Peoples Home residents and managers/clinical leads delivered through an MDT approach including the following service
		1. Primary Care
		2. Social Care
		3. Older Peoples’ Physical and Mental Health Services
		4. Dietetics
		5. Palliative Care
		6. Physiotherapy
		7. Specialist Nursing Services
		8. Integrated Care Homes Pharmacy Team
		9. Community Pharmacy
		10. Any other relevant service determined by the patient’s needs.
		11. Occupational Therapy
	2. **Support Person-centred care –** for good health and wellbeing of Nursing Home residents, and to maintain as much as possible independence and quality of life, including end of life.
	3. **Support management of risk** – ensure escalation of clinical and environmental risk in the home is identified and risks are reported.
	4. **Infection Prevention & Control** – ensuring good infection control measures are in place. Due to Covid-19, Nursing/Older people Homes are currently part of the National Testing Programme. Movement of staff between homes is reduced where possible.
	5. **Workforce** – working with Contractors to support workforce development and identification of training opportunities, as well as mobilising health and care system partners, local colleges, Health Innovation Network (HIN), Social Care Institute for Excellence (SCIE) and others. Apprentice programmes, Registered Manager and Clinical Leadership development.
	6. **Technology** – to work with Contractors and other partners to develop local plans to maximise the technological opportunities for Nursing/Older people Homes – including record keeping, remote monitoring systems and use of assistive technology
	7. **Neighbourhood working** – oversight by the NWDA will ensure that Nursing/Older Home residents, their families and staff feel connected to, and supported by, their local communities – including the use of social prescribing link workers, local Lambeth volunteer services, interested Community Connectors and other voluntary and community groups
2. **Specification Ambitions and Principles**

2.1 This Service specification will ensure that in addition to the requirements set out in the PCN network DES, the Contractor will support their Nursing/Older Home residents to achieve the following outcomes:

* + 1. Better continuity of care, joint working and improved communication between Nursing/Older Home staff and all Contractors i.e., GPs, pharmacists, social care, community services, secondary care, and South East London Doctors on Call (SELDOC).
		2. Develop strong relationships with care home management and staff
		3. Improved service user and carer experience and increased satisfaction of Nursing/Older people homes staff through stronger working relationships with healthcare Contractors
		4. Better communication and involvement of residents, their families/closest friends around end of life, with an aim to offer Advanced Care Planning to all and Universal Care Plan to be used as a preferred tool for recording.
		5. End of life wishes up-held, so residents are supported to die in their preferred place
		6. Reduction in out of hours service usage, London Ambulance Service call out rates and inappropriate or unwanted admission to hospital which could be measured via SUS data.
		7. Improved medication adherence and minimising harm from medication side effects and interactions
		8. Improvement in quality of care received in homes
		9. Proactive management and support of patients’ long-term conditions to achieve better outcomes
		10. Deliver evidence based, and best practice care to residents
		11. Identification of undiagnosed dementia
		12. Enhanced quality of care and clinical decision making through better use of technology in Nursing/Older people Homes to enhance the coordination and access to health care records

2.2 Requirements for the delivery of Enhanced Health in Care Homes (EHCH) by primary care networks (PCNs) are included in the [2020/21 Network Contact DES](https://www.england.nhs.uk/publication/des-contract-specification-2020-21-pcn-entitlements-and-requirements/) and [associated guidance](https://www.england.nhs.uk/publication/des-guidance-2020-21/), with corresponding requirements for community health services and other NHS Contractors in the [NHS Standard Contract](https://www.england.nhs.uk/nhs-standard-contract/19-20/). These requirements were fully implemented from 1 October 2020, with preparatory requirements completed by 31 July 2020, which include:

* + 1. every care home being aligned to a named Primary Care Network (PCN)
		2. every care home having a named clinical lead
		3. a weekly ‘home round’ or ‘check in’ with residents prioritised for review based on MDT clinical judgement and care home advice (this is not intended to be a weekly review for *all* residents)
		4. within 7 days of re/admission to a care home, a resident will have a person-centred holistic health assessment of need (will include physical, psychological, functional, social, and environmental needs of the person and can draw on existing assessments that have taken place outside of the home, if it reflects their goals)
		5. within 7 days of re/admission to a care home, a resident will have in place personalised care and support plan(s), based upon their holistic assessment
		6. the Network Contract DES also has a contractual requirement to prioritise care home residents who would benefit from a [Structured Medication Review (SMR)](https://www.england.nhs.uk/primary-care/pharmacy/smr/).

2.3 [The Enhanced Health in Care Homes Framework](https://www.england.nhs.uk/publication/enhanced-health-in-care-homes-framework/) has been updated to support the delivery of the minimum standards described in these contracts and sets out practical guidance and best practice for Integrated Care Boards (ICBs), PCNs and other Contractors and stakeholders as they work collaboratively to develop a mature EHCH service and should be read alongside these contractual requirements.

1. **Service Model -** The contractor will deliver the general practice contract for the registered patients in line with this service.
	1. Each Nursing /Older Home will have a named clinical lead that shall take responsibility for delivery of the service within Core Hours when the lead GP is unavailable, to enhance continuity of care
	2. The Contractor will have a named administrative lead to oversee management of the contract
	3. The named administrative representative is responsible for being a key point of liaison with the Nursing/Older people Homes and other Contractors and shall be responsive within Core Hours to all MDT participants including GSTT Community Services, Hospice colleagues etc when arrangements, planning and follow-up liaison is required for effective MDT meetings to take place, as required by the EHCH PCN DES specification.
	4. The Contractor will work with the care home staff and others such as GSTT as the community service Contractor, to agree how this will operate to ensure there is a fair distribution of workload in managing and operating the Nursing/Older peoples Home MDTs
	5. The Contractor will prepare a schedule of when and by whom the weekly proactive visits will take place that is shared with Nursing Home staff and community service partners to best plan and prepare for the care reviews/ assessments of residents, prioritising new admissions and medicines reviews. This will enable all parties to plan and prepare for this visit and enable a mechanism for concerns and issues raised by residents, staff teams and relatives to be addressed in a time efficient way.
	6. GP out of hours service to support medicines review of emergency placements into a Nursing home (on weekends and Mon-Friday after 6.30pm)
	7. In addition to weekly visits, ensure virtual access for Nursing/Older people Homes requiring support and advice. Virtual access will include combinations of telephone, video call and email support.
	8. Ensure participation in risk identification and subsequent reporting requests i.e. clinical alerts and safeguarding issues. The Contractor will be encouraged to respond to and support quality alert investigations where necessary to ensure the Service can demonstrate improvements in the quality of its service and processes.
	9. The Contractor will ensure that contingency arrangements are in place to provide full cover for delivery of the EHCH service, should planned or unplanned changes in service or workforce arise. This should be detailed in Contractor business continuity plans with a specific section related to Nursing Home provision given the vulnerability and complexity of these residents and the risks posed by the continuation of the Covid-19 pandemic.
	10. The Contractor will ensure that all Nursing/Older Home residents and their family members receive clear information in a convenient, accessible form on admission to the Nursing home, which sets out how they can best access the practice, when the weekly visit takes place and how they can feedback on the service if required.
	11. The Contractor will support staff and residents to be immunised by following the appropriate and current guidelines on Flu and Covid19 vaccination programmes
	12. The Contractor will ensure they support weekend transfers with appropriate medicines management and support.
2. **Multidisciplinary Team (MDT)** *(\*Note – MDTs are a requirement of the PCN Network DES. The MDT process outlined here will be an additional support to the DES, including a more holistic approach with a wider range of disciplines included to support residents)*
	1. The MDT should use risk stratification tools and clinical judgement to ensure it focuses attention on those individuals with the greatest potential to benefit from being seen during the home round.
	2. This must involve, use of a risk stratification tool to identify those people who are at high risk of unplanned hospital admission, as well as the insight of the Nursing/Older home staff who are experts in knowing the individual’s usual presentation(s) and any deviations from this.
	3. The MDT will meet weekly. The function and format of this meeting should be locally determined dependent upon the needs of those people resident in the Nursing/Older Home, and those individuals identified as requiring MDT input.
	4. People who might be part of the MDT include (but are not limited to):
		1. The Residents Family and next of Kin
		2. Contractor Lead GP/Deputy in their absence
		3. Community Service Contractor Staff (GSTT)
		4. Assigned Consultant Geriatrician
		5. Local Authority Staff (to be specified) Nursing Home Staff
		6. Integrated Care Homes Pharmacy Team
		7. Practice Pharmacist
		8. Physiotherapist
		9. Occupational Therapist
		10. Speech and language therapy
		11. Tissue viability
		12. Strength and balance
		13. Psychiatrist/SLaM Care Home Intervention Team
		14. Stroke and neuro-disabilities
		15. VCS representatives/workers
		16. Social Prescribing Link Worker assigned to the Nursing Home
	5. The MDT must review the information available to them prior to the meeting taking place and work together to determine the appropriate response to needs identified e.g. i) clinical input from the MDT, ii) onward referral to a co-opted MDT member or other, iii) maintenance of current personalised care and support plan *This list is not intended to be exhaustive, and other responses will also be appropriate.*
	6. The home round usually follows the MDT meeting, with all MDT members agreeing the most appropriate clinician to assess the person on each occasion (this will be determined by clinical need and the skills within the MDT, noting that skills are likely to be enhanced and change over time).
	7. The MDT provides a proactive and preventative approach to support people living in a Nursing/Older Home. The MDT uses a partnership approach to clinical governance and decision making with social care staff being core team members.
	8. Membership of the MDT outside of the core team will vary depending on the local expertise and resources available and the needs of the care home population.
	9. All members of the MDT should have access to shared care planning and shared care records through information sharing protocols established across all system partners. Where risk to safety and quality is identified, MDT considers the approach that best supports residents.
3. **Home Round** *(\*Note – Home Rounds are a requirement of the PCN Network DES. The home round as part of the Service Specification will offer an additional support to the DES, ensuring it feeds in to the MDT process noted above)*

5.1 The home round will be led by a clinician with advanced assessment and clinical decision- making skills.

5.2 In advance of the home round, the Lead Clinician and in their absence the Deputy will be sent a list of individuals who will be discussed and reviewed. Identification as stated previously will be through use of validated tools, clinical judgement and feedback from Nursing Home staff.

5.3 The Lead Administrator will collate relevant information pertaining to those individuals from a number of sources of care (e.g. GP, community services, the individual and their family) to be ready for review within the home round and for the MDT to individually appraise their home round patients to determine if they need to physically review the person(s), or can make a clinical judgement based on the information provided within the meeting and to set review dates for each person for follow up.

1. **Quality improvement and development of the service model**

6.1 During the Covid-19 pandemic there has been a need for General Practice and Nursing/Older people Homes to adopt more frequent use of video consultation and remote monitoring technology which has resulted in significant change to the service model in Primary Care. It is also recognised that practices have developed over the years, many effective and efficient ways of serving their Nursing/Older Home residents and hence there is value in having the opportunity to share this for learning purposes.

6.2 Given the critical importance of relationships between Nursing Home staff, primary and community care services in the delivery of the EHCH service model, there is an opportunity for all parties to maximise development and learning opportunities through delivery of this specification.

* + 1. Continue to participate in the Care Homes Partnership Working Group and share best practice with colleagues who are involved in providing services to
		2. Undertake a digital needs analysis with the Nursing/Older people Homes to establish all digital opportunities that exist to ensure all parties are maximising use of Universal Care Plans etc. This will include an options appraisal for remote monitoring
		3. Meet on a regular basis with Nursing/Older Home staff and management to discuss any operational and process challenges that relate to the effective running of the EHCH service requirements and identify required actions to improve this for all parties. Information and actions to be shared with commissioners, as part of contractual assurance
		4. Triage and respond to urgent requests for medical advice on the day they are requested based on agreed protocols. In an urgent clinical situation this will avoid an unwanted, unnecessary, or clinically inappropriate hospital admission
		5. Review acute urgent prescriptions within 24 hours of the request
		6. Implementation of Proxy Access ordering of prescriptions
1. **Applicable quality requirements**

7.1 Advance Care Plans must be recorded in a way that is useful for healthcare professionals who may be required to attend to the patient in an emergency. Where the Nursing/Older Home does not have the infrastructure to access the electronic Universal Care Plan, a paper copy should be filed in the care home records and shared with relevant services. The Contractor should aspire to working with the Nursing Home to be able to access the electronic Universal Care Plan in the first 12 months of the service specification.

7.2 All Contractors should liaise and work together with Adult Safeguarding colleagues to support adults at risk of abuse and neglect.

1. **Care Planning**
	1. To avoid crisis situations arising, the Contractor shall:
	2. Ensure that all Nursing Home residents have the relevant details of their care plan published on Universal Care Plan and ensure that all key parties (Nursing Home/Older staff, residents, their families and other healthcare professionals as appropriate) have been party to preparing the plan and have a means to access it and know their role/ contribution in delivering it
	3. Update UCP plans after any major review so that other Contractors have access to the most up to date details for patients
	4. Where time and resources are limited, the advance care planning process should not be rushed, but appropriate time found as soon as reasonable to complete the task with care and compassion. It is recognised that advance care planning is often by its nature a process that takes place over time rather than a single task. Some Nursing/Older people Homes still use PEACE as the framework for EOL planning. Contractors are advised to use the Advanced Care Planning guidance below:

https://[www.nice.org.uk/about/nicecommunities/social-care/quickguides/advance-care-planning](http://www.nice.org.uk/about/nicecommunities/social-care/quickguides/advance-care-planning)

<https://www.bgs.org.uk/resources/resourceseries/end-of-life-care-in-frailty>

* 1. Where possible, primary care clinicians should share information on the level of frailty of residents (mild, moderate, severe frailty) with Nursing/Older people Homes, and use the Clinical Frailty Scale/eFI Score to help inform urgent triage decisions and holistic assessment and care planning where useful and relevant:
	2. Triage and respond to urgent requests for medical advice on the day they are requested based on agreed protocols'
	3. Review acute urgent prescriptions within 48 hours of the request
1. **Personalised Care and Support Plans (PCSPs)**

9.1 In developing the personalised care and support plan, it is good practice to follow the standard model of personalised care and support planning set out in Universal Personalised Care. [https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-](https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/) [comprehensive-model/](https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/)

9.2 Where people living in Nursing/Older people Homes are identified as likely to die within the next twelve months, the personalised care and support plan will include information on the person’s priorities and preferences for end of life care, advance care planning and treatment escalation plans or emergency care and treatment plans including arrangements to coordinate across multiple Contractors. Personalised care and support plans will also need to include plans with regards to DNACPR.

* 1. Where people living in Nursing/Older people Homes are likely to die within the next few days or hours, appropriate communication with the family will take place. It is also best practice, that food and fluid support and anticipatory prescribing have been considered, and that the personalised care and support plan has been checked so that, where possible
		1. the person dies in their preferred place, and arrangements for timely verification and
		2. certification of death and signposting to bereavement support are in place

**10. Payment**

*\*Payment covered as part of Schedule 4.*

**11. Training**

11.1 Training should be undertaken, if necessary, to achieve the key objectives within this specification. There should be a focus on an integrated workforce that supports staff retention and staff wellbeing.

* + 1. The named lead/deputy clinician responsible for the Nursing/Older people Homes should be capable of recording care plans on UCP
		2. GPs, Nurses, and Practice Pharmacists/ working in Nursing/Older people Homes as part of this service specification need to be skilled in structured medication and polypharmacy review and de- prescribing.
		3. commissioner led training
		4. the contractor should support their nursing teams to access appropriate training if they have a role in supporting advanced care planning in Nursing/Older people Homes
		5. Education, training, and professional development should be made available to help ensure that carers, families, and care home staff feel supported and confident in identifying and managing the mental health needs of individuals and helping them to prevent self-harm and suicide
		6. the contractors Clinical Leads need to have a working knowledge of the principles of Comprehensive Geriatric Assessments, dementia assessments, Safeguarding, MCA, falls prevention and management. advanced care planning and managing multimorbidity & polypharmacy. Leads need to ensure appropriate training is undertaken as necessary
		7. If new templates are introduced appropriate training will be provided. Contractors need to ensure the templates are utilised appropriately so that data is coded correctly and can be collected to inform better management of Nursing Home residents
		8. the contractor should ensure that staff involved in the care of Nursing Home residents are supported to attend as much training as is required to develop and maintain their knowledge and competence
		9. The nominated Clinical Lead shall support training of the Nursing Home staff through linking in with the MDT meetings and organisations