# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

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| **Service Specification No.** |  |
| **Service** | Residential and Nursing Care for People with Profound and Multiple Learning Disabilities and Complex Needs (Granville Court inc. Millside) |
| **Commissioner Lead** | Assistant Director – Services for Vulnerable People ERYCCG |
| **Provider Lead** | TBC following procurement or managed change |
| **Period** | 15/10/2016 – 31/03/2021 |
| **Date of Review** | 01/04/2017 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   This Specification is informed and underpinned by national and local legislation, policy, procedures and practice guidance. This includes but is not limited to;   * *Building the right support* (LGA, ADASS, NHSE, 2015), * *Transforming care for people with learning disabilities - next steps* (ADASS, CQC, DH, HEE, LGA,NHSE, 2015), * *Raising our sights: services for adults with profound intellectual and multiple disabilities* (Mansell, University of Kent, 2010), * *No Secrets* (DoH 2000), * *Six lives: progress report on healthcare for people with learning disabilities* (DH, 2013), * *Improving the Life Chances of Disabled People* (Strategy Unit 2005), * Care Act 2014 * Mental Capacity Act 2005, * Deprivation of Liberty Safeguards 2007, * Care Standards Act 2000, * *Putting People First* (HM 2007), * *Valuing People Now* (DoH 2009), * *A Vision for Adult Social Care* (DoH 2010), * *Prioritising Need in the Context of Putting People First* (DoH 2010), * East Riding of Yorkshire Safeguarding Adults Board Strategy 2013- 2016. * East Riding of Yorkshire Learning Disability Development Plan 2009 - 2014 |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **x** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **x** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **x** | | **Domain 4** | **Ensuring people have a positive experience of care** | **x** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **x** |   **2.2 Local defined outcomes** |
| **3. Scope** |
| **3.1 Aims and objectives of service**  This service is expressly for a very small group of individuals who have profound and multiple learning disabilities and complex needs. These needs are so severe that it has been agreed a residential or nursing care package is the least restrictive way to meet those needs.  Service users are likely to have a range of physical healthcare needs in addition to their profound and multiple learning disabilities, including but not limited to epilepsy, PEG feeding, dysphagia and other nutritional challenges, postural support needs and significant mobility needs.  The current service is for ten residents with nursing needs, five other residents and two bedrooms used by four individuals accessing short breaks.  The service aims are to:   1. Provide a high quality person-centred service to individuals with profound and multiple learning disabilities and complex physical needs which can be best met in a registered care home setting 2. Provide advice, support and short breaks as required for individuals with similar needs who live with family carers 3. Improve outcomes and quality of life for those individuals requiring care in this environment, enabling them to live as independently as possible with as little intervention as possible.   Over the duration of the contract the service objectives are to:   * sustain the progress that has been made over the past year in improving the quality and safety of care provided for this vulnerable client group * increase opportunities for on and off-site activities for the residents in order to give the best possible quality of life * integrate health and social care staff in the current service * ensure the right staffing model to provide safe, high quality, person-centred care, with flexibility built in to ensure changing needs can be met and to support planned activities   There are some additional objectives linked to phase 2 of the procurement:   * agree with residents and their families or carers as well as commissioners a new service model for development * work with commissioners to ensure continuity of care during the move to a new site more centrally located in East Riding of Yorkshire * manage the transfer of existing residents to either the new site or an alternative service, based on the agreed care plan for each resident.   **3.2 Service description/care pathway**  The Provider will:  **3.2.1 Service Requirements:**   1. provide 24 hour support that shall include but is not limited to:   a) providing specialist nursing care to meet the complex health needs of service users  b) providing support to develop social skills in order to develop and maintain relationships with friends and family,  c) providing support to develop, progress and maintain daily living skills to increase independence,  d) working with connected professionals, friends and family to resolve ongoing issues, arrange appointments and support with health needs,  e) providing personal care support,  f) working in partnership with the Commissioner to meet the Service Users’ needs, providing evidence relating to the progression of the Service User on a yearly basis or more frequently if required,  h) providing support to access day services, community activities, and evening activities.   1. work to the outcomes detailed in the service user’s Support Plan as set out in their Individual Care Plan or Service Contract. The service user’s views and preferences, and where appropriate the views of his/her family/friends, should always be central to all discussion as to how those outcomes should be achieved. 2. deliver the care of the existing service users, including both permanent residents and short break users, and will work with the Commissioners to agree care plans for additional service users as required up to the agreed maximum occupancy for the service.   **3.2.2 Involvement and Information**   1. provide all practicable help to encourage and support service users to express their views, choices and preferences about the way their care and support is delivered. This will include documenting when the service user’s consent has been obtained or evidence that the person lacks the mental capacity in regards to that decision and evidence of considerations/options in making a Best Interests decision on service user’s behalf. 2. ensure that service users and their families or carers are fully involved in decisions relating to the overall service provision, and will provide evidence of this engagement and involvement to Commissioners at least annually. For example the views of service users and their families or carers should be sought when recruiting new permanent staff, or when making significant changes to facilities on site. 3. ensure staff operate the service in a way that upholds and maintains service user’s privacy, dignity and independence 4. ensure that staff respect the rights of service users to make their own decisions, even if these conflict with the view of family and/or professionals. Where such decisions would result in a level of risk being taken, the Provider will take necessary steps to manage that risk. 5. ensure that staff take regular account of individual choices and preferences and balance personal choice with risk. Staff will also discuss and explain their care and support plan options with service users and their carers 6. encourage and support service users to give them feedback about how they can improve their services and act on the feedback given. 7. ensure that staff support service users to maintain relationships with family, friends and the community in which they live and will support service users to play an active role in their community. 8. develop and provide information to enable service users to make informed decisions about the care and support they receive. 9. ensure that service users and their carers are enabled to exercise the greatest possible control over the service they receive and service users should be at the centre of any planning concerning their service. 10. ensure that staff are trained to understand how to use the Mental Capacity Act 2005 in practice whereby staff know how to support service users to make decisions/give consent as well as how to determine lack of capacity and act in the best interests of service users as well as engage/support other professionals in the role of the decision maker. 11. provide service users with sufficient information in an appropriate format relating to decision in order to support/enable informed consent and ensure this is kept up to date. 12. discuss and explain the risks, benefits and alternative options to the way services can be delivered with both service users and Commissioners. 13. support service users to access advocacy services to help them make informed decisions and, where appropriate, refer to an Independent Mental Capacity Advocate service as required by the Mental Capacity Act 2005. 14. where appropriate, provide care and support as outlined in advance decisions (inclusive of decision to refuse life-sustaining treatment), Lasting Powers of Attorney and court appointed Deputies in accordance with the Mental Capacity Act 2005. 15. provide care and support following the least restrictive principle of the Mental Capacity Act 2005, recording and reviewing any restrictions or restraints applied. 16. where appropriate, act in accordance with Deprivation of Liberty Safeguards 2007 to fulfil the role of the Managing Authority by ensuring authorisations are in place for service users whose care/support amounts to a deprivation as per the Supreme Court ruling 2014.   **3.2.3 Personalised Care and Support**   1. recognise and demonstrate that the service is aimed at enhancing the quality of people’s lives, to enable them to live as independently as possible with as little intervention as possible, recognising the worth of all people and their right to be treated with respect and supported to live in a dignified manner 2. ensure that where appropriate, service users are supported to have a communication support plan 3. ensure that staff are enabling service users to undertake self-care and practical tasks for themselves wherever possible 4. ensure that staff are enabling service users to retain control and make decisions relating to matters of daily living wherever possible 5. ensure that service users are involved in their care and support planning and supported to set goals to help maximise their independence and improve the quality of their life 6. ensure that the care and support plan produced is clear, accessible and detailed to enable all staff to provide effective support for the service user 7. provide appropriate transport and/or support use of public or patient transport to facilitate a range of offsite activities, including attendance at healthcare appointments as agreed in individual care plans 8. ensure that service users are supported to have 24 hour access to a choice of food and drink that takes into account their preferences, needs and dietary requirements, any specific dietary issues are documented and reviewed as changes occur 9. ensure that there is continuity of care in relation to diet and nutrition between the services accessed by the service user 10. cooperate and communicate with other providers of the service user’s care and support when this responsibility is shared 11. ensure that the care and support plan includes effective arrangements for when service users are transferred to another service, including temporary transfers, ensuring that this includes everything the receiving service needs to know, to the needs of the individual can continue to be met safely and effectively 12. support service users to access other social care or health services, such as occupational therapy, speech and language therapy, mental health services, dietitian or GP, providing staff to escort residents where required 13. ensure that there is continuity of care between providers of the service user’s care and support   **3.2.4 Safeguarding and safety**   1. ensure that staff are trained to enable them to safeguard service users from all forms of abuse. The Provider shall also monitor the implementation of policies and procedures concerning safeguarding by reviewing care and support for individual service users, organisational policies and procedures and staff competencies. Such organisational policies and procedures will be in line with the East Riding of Yorkshire Safeguarding Adults Board Strategy. 2. ensure staff are aware of and follow their responsibilities in relation to safeguarding and whistle-blowing 3. take action to identify and prevent abuse from happening in the service and respond appropriately when it is suspected that abuse has occurred or is at risk of occurring. 4. ensure staff understand the interface between the Mental Capacity Act, Deprivation of Liberty Safeguards and the Human Rights Act safeguarding principles. Service Users must be assumed to have mental capacity unless there is evidence to show otherwise, in which case decisions made on their behalf must be in their Best Interests and least restrictive of their right and freedoms. Deprivation of Liberty Safeguards can only be used in the Best Interests of the Service User and in accordance with the Mental Capacity Act 2005. Unauthorised deprivation of liberty constitutes abuse and must be reported as such. 5. review and update the service user’s care and support plan to ensure that individuals are properly supported following any incidents or allegations of abuse 6. give service users and their carers adequate information about how to identify and report abuse, as well as sources of support outside the service, and actively support and encourage service users and their carers to raise issues and concerns when necessary 7. make safeguarding a meaningful issue for service users and support service users and their carers when they have to take part in any safeguarding processes 8. have effective arrangements in place to maintain appropriate standards of cleanliness and hygiene for the prevention, management and control of infection as identified in *Prevention and control of infection in care homes – an information resource* (DH/HPA, 2013) 9. provide sufficient information to service users, staff and visitors about infection prevention and control matters 10. have appropriate arrangements in place for the management an disposal of clinical waste 11. have clear policies and procedures to enable staff to administer all medication safely, securely and appropriately 12. ensure that medication and homely remedies are stored and administered safely in accordance with instructions from the relevant medical practitioner and appropriate records kept 13. respect the service user’s right to refuse medicine on any occasion 14. ensure medication is not given without the valid and informed consent of the service user. Where the service user lacks capacity to give informed consent, a best interest decision in accordance with the Mental Capacity Act should be recorded in the medication records. 15. keep records in the service user’s Care and Support Plan 16. ensure that staff handling medication undertake any required training and competency assessment, following the advice and guidance provided by the Commissioner’s medicines management team 17. immediately take medical advice in the event of a mistake occurring, and fully investigate, document and take necessary measures to prevent recurrence. When a mistake occurs, the Provider will report it to the appropriate body in line with safeguarding policy and practice 18. ensure that continuity of care is maintained when a service user is receiving support with medication from more than one provider 19. ensure that the premises and environment are safe, suitable for the purposes of the services and meet all current legislation 20. ensure that premises take account of service users with specific needs and that effective risk management is in place to reduce identified risks, and have appropriate security arrangements in place to address the risk of unauthorised access, to protect the people who use the home 21. ensure that, where appropriate, service users are consulted regarding any material or cosmetic change to the service 22. ensure that staff undertake fire safety training as well as risk assessment and risk management training 23. ensure that equipment in the property is regularly tested and maintained, and repaired in accordance with the manufacturer’s recommendations. Records will be kept of all safety checks undertaken   **3.2.5 Suitability of staffing**   1. have effective recruitment and selection procedures in place that comply with General Condition 5 of the Standard NHS Contract terms and conditions 2. ensure that service users and their family/carers and/or advocates are involved in the recruitment process appropriate to their level of understanding 3. ensure that when staff are provided by an external organisation or agency those staff have been subject to the same level of checks and selection criteria as employed staff 4. ensure that all staff have a clear understanding of their role and responsibilities including reading care and support plans for the service users they will be working with 5. have robust and effective arrangements around the appropriate behaviour of staff, particularly in relation to their code of professional conduct and the assessment of stress and other work related hazards. The Provider shall also demonstrate that staff have agreed and understood this information 6. make sure that there are sufficient staff on duty with the appropriate knowledge, experience, qualifications and skills to provide effective care and support in line with each service user’s care and support plan. 7. have robust mechanisms in place to manage both expected and unexpected changes in the service in order to maintain safe, effective and consistent care, for example to cover sickness, vacancies, absences and emergencies 8. ensure that all staff receive an appropriate induction at the start of their employment in line with the Skills for Care common induction standards and/or nursing registration requirements. The Provider shall evidence how this learning is embedded in practice for each member of staff 9. ensure that all non-registered either hold a current care certificate or meet the requirements of the care certificate or have clear personal learning objectives that include appropriate training to meet these requirements 10. ensure that all staff receive appropriate 1:1 face to face supervision at least 6 weekly with additional support as identified and including an observation of practice at least twice a year and that their performance is appraised and that they receive an annual appraisal. For clinical staff this must meet the requirements of the relevant professional body to maintain and or revalidate registration. All of the above are formally recorded, signed and stored securely at the service. 11. ensure that all staff undertake mandatory training that meets the Commissioner’s minimum training standards and refresh this on a regular basis as required. The Provider shall also maintain a training matrix detailing staff training records (including evidence of attendance) 12. support staff to develop themselves professionally by acquiring further skills and qualifications that are relevant to their role, the work they undertake and the needs of the service 13. ensure that all staff undertake any appropriate specialist training to meet the needs of service users. In particular the Provider will ensure staff are able to communicate effectively with service users, e.g. through the use of Makaton and other non-verbal communication 14. assess risks that may impact on performance and make reasonable adjustments to enable staff to fulfil their role 15. have appropriate policies and mechanisms in place to prevent and manage incidents of bullying, harassment and violence towards Staff. 16. have robust and effective Human Resources arrangements in place to manage sickness and other absences including the assessment of stress and other work-related hazards so as not to diminish the care and support for the Service User(s). 17. register with the Skills for Care National Minimum Dataset for Social Care (NMDS-SC). The Provider shall also complete an NMDS-SC organisational record and update all organisational data at least once per year. They will also complete NMDS-SC records for all Staff and updated at least once per annum. 18. enable the sharing of NMDS-SC data with Commissioners by ticking the appropriate check box within your account. 19. monitor the working hours of all Staff across Services to ensure that any working patterns do not have a detrimental impact on the care and support of Service Users. 20. inform the Safeguarding Lead and the Access to Resources Team immediately in the event of an allegation of misconduct, and the Safeguarding Lead shall advise on the action to be taken. In such an instance the Safeguarding Lead may require actions to be taken up to and including the removal of the named worker(s) pending the outcome of an investigation. This may be deemed necessary in order to protect and support the named worker(s). 21. have a procedure in place concerning the suspension without prejudice of individuals who are the subject of allegations of serious misconduct. The procedure should also ensure that Staff undertake responsibilities to report members of staff within this process to the Independent Safeguarding Authority.   **3.2.6 Quality Assurance**   1. have a robust quality assurance process on at least an annual basis that continually gathers and evaluates information about the services delivered, to ensure that people receive safe and effective care and support. This shall include gathering the views of Service Users and their friends and family where possible. 2. improve services by learning from, and acting on, any information including, but not limited to: comments and complaints, safeguarding issues, incidents, adverse events, errors or near misses, audits and local or national reviews. Any reports will be shared with the Commissioner on request. 3. have sufficient management capacity and support to enable the Service to function safely and effectively. 4. ensure that senior staff will be deployed to allow on-site support and mentoring. 5. ensure that learning from all quality assurance and comment/complaints process is taken and shared to improve the experience of Service Users. 6. ensure that a manager who is not responsible for the Service carries out 6 monthly quality assurance checks of the Service to oversee the running of services and check finances are appropriately managed. A report of this visit will be sent to the Commissioner on request. 7. ensure that all staff declare any interest or involvement within the organisation or with any other separate organisation providing support services, or responsible for commissioning or contracting those services. The Provider will keep a register that is open to inspection and includes risk assessments where necessary. 8. provide service users and their carers with accessible information, about the complaints/comments process, including information on how to contact the Commissioner, the Parliamentary and Health Service or Local Government Ombudsman and the Care Quality Commission. 9. ensure that staff support service users to raise a complaint or make comments about the service and promote the use of advocacy services, if this is required to enable a Service User to make a complaint or raise a comment about the service. 10. consider fully, respond appropriately and resolve, where possible, any comments and / or complaints and support people throughout the process keeping them informed of the progress and outcome of their complaint in a timely manner. 11. keep comprehensive records about the complaint, including any relevant and factual information about the investigation, responses, outcome and actions taken. 12. share details of complaints with the Commissioner within 7 days of the incident and the outcomes of the process within 7 days of the conclusion of the process. 13. inform the Case Manager and the Continuing Healthcare or Access to Resources Team, or the Emergency Duty Team outside normal working hours, within 12 hours and confirm in 12 hours if any of the following occur:   i. A serious accident to the Service User or Staff  ii. Allegations and/or incidents of abuse to the Service User  iii. A Service User being admitted to hospital  iv. A Service User requests cancellation of the service or has ceased to reside in their home  v. A Service User fails to engage with the care worker and refuses the support services.  vi. A Service User dies.   1. inform the Case Manager and the Continuing Healthcare or Access to Resources Team within three working days if there is any change of circumstances indicating that the care and support plan may require review or revision by the Commissioner. 2. ensure that they are registered with the Information Commissioner’s Office for at least the full term of the Contract and shall provide evidence of this to the Council. 3. ensure that the personal records of Service Users are clear, accurate, factual, complete, personalised, fit for purpose, up-to-date, held securely and remain confidential. This will include but not be limited to details of any 1 to 1 support hours, diary sheets and rotas. 4. keep all financial records relating to any Service User for a minimum of seven years after the end of their service and all other records relating to them for a minimum of three years. 5. ensure that all records relating to staff and Service Users are kept securely on the provider’s premises, with a copy in the Service where the two premises are not the same, and are available for inspection on request by an authorised officer of the Commissioner. 6. use these records to plan the care and support of the Service User to help ensure that the Service User's rights and best interests remain protected and their needs are met. This includes effective and accurate record keeping in relation to Deprivation of Liberty Safeguards and its statutory notification to the Care Quality Commission. 7. only share information in line with the Data Protection Act 1998 including but not limited to with the consent of the Service User, as legally required or in line with the Contract. Care plans will demonstrate how Service Users have been supported to give consent to their records being shared. 8. only keep and store records in line with the Data Protection Act 1998 and in line with the Commissioner’s requirements as set out in the contract. 9. support Service Users to access information about their care and support when they request it. 10. ensure that when information is inappropriately shared, transferred or lost, this is reported to the Commissioner, investigated and acted on in accordance with the appropriate incident reporting procedures. 11. ensure that other records necessary for the operation and management of the service are stored in accordance with the Provider's and Commissioner’s policies and procedures. 12. monitor the standards of practice through a programme of effective audits. This should include but not be limited to checks being carried by a manger who is not working within the Service at least monthly. These checks shall include finance, Care and Support Plans and Staff support, and shall be shared with the Commissioner on request 13. reconcile the amount and purpose of all financial transactions undertaken on behalf of the Service User individually and sign and date this along with the Service Users where possible. 14. ensure Service Users are supported to have a financial support plan which includes appropriate risk assessments and capacity assessments, thus ensuring an appropriate level of choice and control over their finances. 15. ensure Service Users are supported to receive all the benefits they are entitled to and are supported to manage their money effectively. 16. ensure that where Service Users are unable to manage their finances and appropriate appointee is established.   **3.3 Population covered**  The population covered is based on the current responsible commissioner guidance for the NHS (*Who Pays? Determining responsibility for payments to providers*, NHSE, August 2013 and amending regulations in force from 1 April 2016) and Local Authorities (*Ordinary residence, Guidance on the identification of the ordinary residence of people in need of community care services, England*, DH, October 2013).  That is, those individuals in the relevant client group who have been assessed as meeting the criteria for fully or joint funded Continuing NHS Healthcare where this is the responsibility of East Riding of Yorkshire CCG or those who have been assessed as meeting the criteria for Adult Social Care where this is the responsibility of East Riding of Yorkshire Commissioner.  The Provider will provide placements for individual referrals, as outlined in 3.4, for which Individual Service Contracts (Appendix 1) will be issued.  **3.4 Any acceptance and exclusion criteria and thresholds**  It will be the responsibility of the East Riding of Yorkshire Adult Joint Commissioning Panel to agree packages of care for the seventeen beds in the current service and the Provider will only accept referrals that have been approved by the panel.  The service is intended for people with profound, complex and multiple learning disabilities, often with significant physical disabilities, for whom a residential or nursing setting is the least restrictive environment to meet their needs.  Following development of new premises on a new site, the Provider, in partnership with the facilities provider, may wish to develop additional services, e.g. independent supported living provision, on the site however the Commissioners cannot guarantee any activity for such services at this time.  **3.5 Interdependence with other services/providers**  Key interdependencies exist with local primary and community healthcare services, in particular the Community Team for Learning Disabilities, adult social services and local leisure facilities. |
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| **4.1 Applicable national standards (eg NICE)**  The Provider of the service is required to be registered with the Care Quality Commission (CQC) and to maintain that registration throughout the Contract Period. The Provider must meet all relevant legislation, including the *Fundamental Standards* included in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and the Care Quality Commission (Registration) Regulations 2009 (Part 4).  The Fundamental Standards are:   * care and treatment must be appropriate and reflect service users' needs and preferences. * service users must be treated with dignity and respect. * care and treatment must only be provided with consent. * care and treatment must be provided in a safe way. * service users must be protected from abuse and improper treatment. * service users' nutritional and hydration needs must be met. * all premises and equipment used must be clean, secure, suitable and used properly. * complaints must be appropriately investigated and appropriate action taken in response. * systems and processes must be established to ensure compliance with the fundamental standards. * sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed. * persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement). * registered persons must be open and transparent with service users about their care and treatment (the duty of candour).   **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**  Although written for people with learning disabilities and/or autism who display behavior that challenges, the five golden threads and several of the nine key principles set out in the service model for commissioners (ADASS, LGA, NHSE, October 2015) are applicable to this service.   |  |  | | --- | --- | | Golden Threads | Key Principles | | 1. Quality of life 2. Keeping people safe 3. Choice and control 4. Least restrictive support and interventions 5. Equitable outcomes | 1. I have a good and meaningful everyday life 2. My care and support is person-centred, planned, proactive and coordinated 3. I have choice and control over how my health and care needs are met 4. My family and paid support and care staff get the help they need to support me to live in the community 5. I have a choice about where I live and who I live with 6. I get good care and support from mainstream health services 7. I can access specialist health and social care support in the community 8. If I need it, I get support to stay out of trouble 9. If I am admitted for assessment and treatment in a hospital setting because my health needs can’t be met in the community, it is high-quality and I don’t stay there longer than I need to |   **4.3 Applicable local standards** |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-D)**   2. **Applicable CQUIN goals (See Schedule 4E)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:**  For the initial period of this contract the service will be provided at Granville Court, Esplanade, Hornsea, East Riding of Yorkshire HU18 1NQ, currently owned by The Spice Trust, a charitable trust set up solely for the purpose of owning a number of similar properties. A license to occupy will be granted, with zero rent payable to the landlord. All building running costs other than cleaning and gardening will be the responsibility of the Commissioners and a schedule of Commissioner responsibilities will be provided. During the contract term the commissioners will procure new premises. The service provider will be fully consulted regarding the impact of moving to new premises. Residents and their families or carers and other key stakeholders will be consulted. The consultation will include the East Riding of Yorkshire Learning Disabilities Partnership Board. This relocation is expected to be achieved within two to three years of the beginning of the contract period. |
| **7. Individual Service User Placement** |
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**SCHEDULE 4 – QUALITY REQUIREMENTS**

**NB: Indicators with grey background would not be applicable to this contract**

## National Quality Requirements

| **Ref** | **Operational Standards/National Quality Requirements** | **Threshold** | **Method of Measurement** | **Consequence of breach** | **Timing of application of consequence** | **Applicable Service Category** |
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| ***E.B.4*** | ***Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test\**** | ***Operating standard of no more than 1%*** | ***Review of Service Quality Performance Reports*** | ***Where the number of Service Users waiting for 6 weeks or more at the end of the month exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold*** | ***Monthly*** | ***CS***  ***D*** |
| E.B.S.3 | Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care\* | Operating standard of 95% | Review of Service Quality Performance Reports | Where the number of Service Users in the Quarter not followed up within 7 days exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold | Quarterly | MH |
|  | Duty of candour | Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident in accordance with Regulation 20 of the 2014 Regulations | Review of Service Quality Performance Reports | Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate | Monthly | All |
|  | Completion of a valid NHS Number field in mental health commissioning data sets submitted via SUS, as defined in Contract Technical Guidance | 99% | Review of Service Quality Performance Reports | Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold | Monthly | MH |
|  | Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users, as defined in Contract Technical Guidance | Operating standard of 90% | Review of Service Quality Performance Reports | Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold | Monthly | MH |
|  | Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance | Operating standard of 90% | Review of Service Quality Performance Reports | Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold | Monthly | MH |
| E.H.4 | Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral | Operating standard of 50% | Review of Service Quality Performance Reports | Issue of Contract Performance Notice and subsequent process in accordance with GC9 | Quarterly | MH |
| E.H.1 | Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral | Operating standard of 75% | Review of Service Quality Performance Reports | Issue of C`1ontract Performance Notice and subsequent process in accordance with GC9 | Quarterly | MH |
| E.H.2 | Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral | Operating standard of 95% | Review of Service Quality Performance Reports | Issue of Contract Performance Notice and subsequent process in accordance with GC9 | Quarterly | MH |

**SCHEDULE 4 – QUALITY REQUIREMENTS**

## Local Quality Requirements

| **Quality Requirement** | **Threshold** | **Method of Measurement** | **Consequence of breach** | **Timing of application of consequence** | **Applicable Service Specification** |
| --- | --- | --- | --- | --- | --- |
| Personalised Care Plan in place, which details the service user’s preferences, needs and wishes and these are being met by the service. This will include, but is not restricted to:   * Preferences on nutrition, hydration and social preferences for eating and drinking * Preferences on living space and environment * Preferences on activities within and outside of their accommodation * Communication preferences and needs * Care needs and preferences   Additionally, the care plan will include evidence that it is regularly updated in line with the service user’s changing preferences and reviewed at least annually in line with the service user’s annual assessment of needs | 100% compliance | Spot-check audit by commissioners at least annually | In accordance with GC9 | At least annually or following any audit process | [This specification ref] |
| Personal response to the service user and their family on any formal complaint raised about the service, with offer of a meeting to resolve the complaint as well as formal letter of response | To be completed for 100% of complaints | Quarterly report on:   * Number of formal complaints raised within the quarter * Number of formal complaints resolved within the quarter * For resolved complaints, accompanying data set to demonstrate how many complaints had offer of a meeting to resolve the complaint and to demonstrate how many formal letters of response sent (data set should show 100% compliance for complaints resolved within the quarter) * Report to also meet requirements of Schedule 6, B, point 4 | In accordance with GC9 | Quarterly | [This specification ref] |
| Service to engage with service users and their family members at least every 6 months for their feed back on the service (opportunity to raise concerns, give praise for the service, make suggestions for improvements, give feedback on the elements to stay the same). Service to produce a summary report from this engagement and provide an action plan to take forward comments provided, and to feed back to service users and their families through a ‘You Said, We Did’ style newsletter/update | To be completed every six months as a minimum | Report to be submitted by the service to meet Quality Requirement | In accordance with GC9 | Every 6 months | [This specification ref] |
| All (clinical and non-clinical) incidents to be reported, investigated and action taken. Service to demonstrate it puts the safety of service users and staff at heart of everything it does and that there is a strong reporting culture and ability for staff to ‘speak up’. | 100% compliance | Monthly report from service to commissioner on:   * Number of incidents reported per month * Breakdown of incident number by severity of incident (no harm, low harm, moderate, severe and catastrophic) * Number of incident investigations completed and number of incident investigations outstanding * Share headline of any incident rated severe or catastrophic harm, lessons learned and summary of actions taken as a result * Share any emerging risks to the service arising from incidents of any severity | In accordance with GC9 | Every month | [This specification ref] |
| Annual Information Governance toolkit return | Continued compliance with IG toolkit standards required | Share report from annual IG toolkit with commissioner – report to demonstrate compliance with relevant IG standards for assurance to commissioner (i.e. same assurance provided as part of IG toolkit submission). Should the toolkit submission demonstrate a risk to continued IG compliance, service to submit action plan for urgent compliance with IG standards | In accordance with GC9 – commissioner will not contract with a provider without relevant IG compliance in place | Annual | [This specification ref] |

**SCHEDULE 4 – QUALITY REQUIREMENTS**

## Never Events

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Never Event Breach** | **Threshold** | **Method of Measurement** | **Never Event Consequence (per occurrence)** | **Applicability** | **Applicable Service Category** |
| The occurrence of a Never Event as defined in the Never Events Policy Framework from time to time | >0 | Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report | In accordance with Never Events Policy Framework, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event | All healthcare premises and settings | All |

**SCHEDULE 4 – QUALITY REQUIREMENTS**

**E. Commissioning for Quality and Innovation (CQUIN)**

**CQUIN Table 1: CQUIN Schemes**

|  |
| --- |
| **Insert completed CQUIN template spreadsheet(s) or state Not Applicable**  To be determined when this specification is being put in to contract |

**CQUIN Table 2**: **CQUIN Payments on Account**

|  |  |  |  |
| --- | --- | --- | --- |
| **Commissioner** | **Payment** | **Frequency/Timing** | **Agreed provisions for adjustment of CQUIN Payments on Account based on performance** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SCHEDULE 4 – QUALITY REQUIREMENTS**

1. **Local Incentive Scheme**

|  |
| --- |
| **Insert text locally or state Not Applicable**  To be determined when this specification is being put in to contract |

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **Recorded Variations**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Variation Number** | **Description of Variation** | **Date of Variation Proposal** | **Party proposing the Variation** | **Date of Variation Agreement** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS**

**B Reporting Requirements (Small Providers only)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Reporting Period** | **Format of Report** | **Timing and Method for delivery of Report** | **Application** |
| **National Requirements Reported Centrally** |  |  |  |  |
| 1. As specified in the list of omnibus, secure electronic file transfer data collections and BAAS schedule of approved collections published on the HSCIC website to be found at [https://rocrsubmissions.ic.nhs.uk/Pages/search.aspx?k=R\*](https://rocrsubmissions.ic.nhs.uk/Pages/search.aspx?k=R*)   where mandated for and as applicable to the Provider and the Services | As set out in relevant Guidance | As set out in relevant Guidance | As set out in relevant Guidance | **Small Providers** |
| **National Requirements Reported Locally** |  |  |  |  |
| 1. Activity and Finance Report | [For local agreement, not less than quarterly] | [For local agreement] | [For local agreement] | **Small Providers** |
| 1. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour | Quarterly | Report to be submitted by service for feedback by commissioner – report to be developed within first year of contract to meet commissioner requirements; | To be submitted quarterly to Commissioner email inbox | **Small Providers** |
| 1. CQUIN Performance Report and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied | [For local agreement, not less than annually] | [For local agreement] | [For local agreement] | **Small Providers** |
| 1. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints | Quarterly | Report to be submitted by service for feedback by commissioner – report to be developed within first year of contract to meet commissioner requirements; to meet specified points of Schedule 4 (B) as a minimum | To be submitted quarterly to Commissioner email inbox | **Small Providers** |
| 1. Report against performance of Service Development and Improvement Plan (SDIP) | In accordance with relevant SDIP | In accordance with relevant SDIP | In accordance with relevant SDIP | **Small Providers** |
| 1. Summary report of all incidents requiring reporting | Quarterly | Report to be submitted by service for feedback by commissioner – report to be developed within first year of contract to meet commissioner requirements; to meet specified points of Schedule 4 (B) as a minimum | To be submitted quarterly to Commissioner email inbox | **Small Providers** |
| 1. Data Quality Improvement Plan: report of progress against milestones | In accordance with relevant DQIP | In accordance with relevant DQIP | In accordance with relevant DQIP | **Small Providers** |
| 1. Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*) | 6 monthly (or more frequently if and as required by the Commissioner from time to time) | Report to be submitted by service for feedback by commissioner – report to be developed within first year of contract to meet commissioner requirements | To be submitted quarterly to Commissioner email inbox | **Small Providers** |
| **Local Requirements Reported Locally** |  |  |  |  |
| For all other requirements not covered by this schedule. Local Requirements Reported Locally to include reporting against Schedule 4(B) requirements | As specified in Schedule 4 | Report to be submitted by service for feedback by commissioner – report to be developed within first year of contract to meet commissioner requirements; to meet specified points of Schedule 4 (B) as a minimum | To be submitted quarterly to Commissioner email inbox | **Small Providers** |

**SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS**

1. **Data Quality Improvement Plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Data Quality Indicator** | **Data Quality Threshold** | **Method of Measurement** | **Milestone Date** | **Consequence** |
| **Insert text locally** |  |  |  |  |
|  |  |  |  |  |

**SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS**

1. **Incidents Requiring Reporting Procedure**

|  |
| --- |
| **Procedure(s) for reporting, investigating, and implementing and sharing lessons learned from: (1) Serious Incidents (2) Reportable Patient Safety Incidents (3) Other Patient Safety Incidents** |
| Provider to share policy on Incident Requiring Reporting. This will include as a minimum:  Process for reporting all clinical and non-clinical incidents  Process for assessing level of harm of all incidents  Process for escalating any incident meeting Serious Incident reporting criteria  Process for logging any Serious Incident on to the national reporting database (STEIS) and reporting these to commissioners  Process for investigating all incidents  Process for identifying lessons learned and action planning from investigation findings and sharing those from serious incidents with commissioners for review and approval per NHS England guidance  Policy must reflect requirements of NHS England Framework for Serious Incidents to meet requirements of (1) above  [To be embedded document within the contract]  Policy must demonstrate how (2) and (3) above are undertaken by the provider  [Provider policy to be embedded document within the contract as document relied upon] |

**SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS**

1. **Service Development and Improvement Plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Milestones** | **Timescales** | **Expected Benefit** | **Consequence of Achievement/ Breach** |
| **Insert text locally** |  |  |  | [Subject to GC9 (*Contract Management*)] or [locally agreed] |
|  |  |  |  |  |

**SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS**

1. **Surveys**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Survey** | **Frequency** | **Method of Reporting** | **Method of Publication** | **Application** |
| Friends and Family Test (where required in accordance with FFT Guidance) | As required by FFT Guidance | As required by FFT Guidance | As required by FFT Guidance | **All** |
| Service User and family survey | Every 6 months | In accordance with Local Quality Requirement in Schedule 4 (B) | Written report to commissioners | **All** |
| Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance) | As applicable to service | Report to be published once survey results collated | Would expect publication by the service on website  To submit report to commissioners with an action plan as a minimum | **All (not Small Providers)** |
| [Other insert locally] |  |  |  |  |

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