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**NHS Standard Contract 2021/22**

**Particulars (Shorter Form)**

***Contract title / ref: Continuing Healthcare***

Prepared by: NHS Standard Contract Team, NHS England

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(please do not send contracts to this email address)

Version number: 1

First published: March 2021

Publication Approval Number: PAR478

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| --- | --- |
| **Contract Reference** | **Continuing Healthcare** |
| **DATE OF CONTRACT** | **6th April 2021** |
| **SERVICE COMMENCEMENT DATE** | **6th April 2021** |
| **CONTRACT TERM** | **4 years** |
| **COMMISSIONERS** | **Upto 15th May 2021**  **NHS Cambridgeshire and Peterborough CCG (06H)**  **Lockton House, Clarendon Road, Cambridge CB2 8FH**  **From 16th May 2021**  **NHS Cambridgeshire and Peterborough CCG (06H)**  **Gemini House, 1 Bartholomew’s Walk, Ely, CB7 4EA** |
| **CO-ORDINATING Commissioner** | **None** |
| **PROVIDER** |  |

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**CONTRACT**

**Contract title: Continuing Healthcare**

**Contract ref:** ……………………………………………………..….

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**;
2. the **Service** **Conditions (Shorter Form)**;
3. the **General Conditions (Shorter Form)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

**IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below**

| **SIGNED by** | **……………………………………………………….**  **Signature** |
| --- | --- |
| **Louis Kamfer for**  **and on behalf of**  **CAMBRIDGESHIRE PETERBOROUGH CCG** | **……………………………………………………….**  **Title**  **……………………………………………………….**  **Date** |

| **SIGNED by** | **……………………………………………………….**  **Signature** |
| --- | --- |
| **[INSERT AUTHORISED**  **SIGNATORY’S**  **NAME] for**  **and on behalf of**  **[INSERT PROVIDER NAME]** | **……………………………………………………….**  **Title**  **……………………………………………………….**  **Date** |

|  |  |  |  |
| --- | --- | --- | --- |
| **SERVICE COMMENCEMENT AND CONTRACT TERM** | |  | |
| **Effective Date** | | **6th April 2021** | |
| **Expected Service Commencement Date** | | **6th April 2021** | |
| **Longstop Date** | | **N/A** | |
| **Service Commencement Date** | | **6th April 2021** | |
| **Contract Term** | | **4 years** | |
| **Option to extend Contract Term** | | **YES** | |
| **Notice Period (for termination under GC17.2)** | | **One months’ notice is required if either party wishes to terminate this contract** | |
| **SERVICES** | |  | |
| **Service Categories** | | **Indicate all that apply** | |
| **Continuing Healthcare Services (including continuing care for children) (CHC)** | | X | |
| **Community Services (CS)** | |  | |
| **Diagnostic, Screening and/or Pathology Services (D)** | |  | |
| **End of Life Care Services (ELC)** | |  | |
| **Mental Health and Learning Disability Services (MH)** | |  | |
| **Patient Transport Services (PT)** | |  | |
| **Co-operation with PCN(s) in service models** | | | |
| **Enhanced Health in Care Homes** | | **NO** | |
| **Service Requirements** | |  | |
| **Essential Services (NHS Trusts only)** | | **NO** | |
| **Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of the Contract?** | | **YES** | |
| **PAYMENT** | |  | |
| **National Prices apply to some or all Services (including where subject to Local Modification or Local Variation)** | | **NO** | |
| **Local Prices apply to some or all Services** | | **YES** | |
| **Expected Annual Contract Value agreed** | | **NO** | |
| **GOVERNANCE AND REGULATORY** | **Provider should have completed separate template and uploaded.** | |
| **Provider’s Nominated Individual** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Information Governance Lead** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Data Protection Officer (if required by Data Protection Legislation)** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Caldicott Guardian** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Senior Information Risk Owner** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Accountable Emergency Officer** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Safeguarding Lead (children) / named professional for safeguarding children** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Safeguarding Lead (adults) / named professional for safeguarding adults** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Child Sexual Abuse and Exploitation Lead** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Mental Capacity and Liberty Protection Safeguards Lead** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **Provider’s Freedom To Speak Up Guardian(s)** | **[ ]**  **Email: [ ]**  **Tel: [ ]** | |
| **CONTRACT MANAGEMENT** |  | |
| **Addresses for service of Notices** | Up to 15th May 2021  NHS Cambridgeshire and Peterborough CCG (06H)  Lockton House, Clarendon Road, Cambridge CB2 8FH  From 16th May 2021  NHS Cambridgeshire and Peterborough CCG (06H)  Gemini House, 1 Bartholomew’s Walk, Ely, CB7 4EA  Email: capccg.communitycontractsteam@nhs.net  Provider:  Address:  Copy to: | |
| **Commissioner Representative(s)** | **Name: Martin Niven, Head of Operations, CHC and Complex Cases**  **Address:**  Lockton House,  Clarendon Road,  Cambridge,  CB2 8FH  **Email:martin.niven@nhs.net** | |
| **Provider Representative** | **Provider:**  **Address:**  **Email:**  **Tel:** | |

# SCHEDULE 1 – SERVICE COMMENCEMENT

**AND CONTRACT TERM**

1. **Conditions Precedent**

The Provider must provide the Co-ordinating Commissioner with the following documents and complete the following actions:

| 1. Evidence of appropriate Indemnity Arrangements including Employers Liability Insurance and Public liability insurance 2. [Evidence of CQC registration 3. [Copies of the following Sub-Contracts signed and dated and in a form approved by the Co-ordinating Commissioner] *[LIST ONLY THOSE REQUIRED FOR SERVICE COMMENCEMENT AND NOT PROVIDED ON OR BEFORE THE DATE OF THIS CONTRACT]* 4. Business Continuity Plan for the home and the organisation. This needs to be updated to reflect Covid 19 pandemic outbreak. |
| --- |

1. **Extension of Contract Term**

*To be included only in accordance with the Contract Technical Guidance.*

**NOT USED**

# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

**01 - Care Homes**

**02 - Domiciliary Care**

|  |  |
| --- | --- |
| **Service Specification No.** | Care Homes 01 |
| **Service** | Care Homes and Care Homes with Nursing |
| **Commissioner Lead** | Complex Cases Team |
| **Provider Lead** |  |
| **Period** | 1st April 2021 |
| **Date of Review** | March 2022 or mandated by NHS E under National framework |

|  |
| --- |
| **1. Population Needs** |
| * 1. **National/local context and evidence base**   This document sets out the care specification and patient focused outcomes in line with the National Minimum Standards for Care Homes Older People 2003 which apply to the provision of care for adults and older people in a care home with nursing. It specifically identifies key indicators of quality care.  This specification reflects national policy advice and guidance and sets out the philosophy and care standards to be adhered to in the provision of the care for adults and older people in a care home with nursing.  All standards produced by the registration authority inspection report (to be the Care Quality Commission report from April 2009) will be considered in conjunction with this document.  The Commissioners will only contract with organisations that are registered, if they are required to do so, with the CQC and meet any other legal requirements relating to the services they provide. The Commissioners expect that all Providers that it commissions will meet CQC regulations and standards, or the standards of another equivalent regulator. If a service is judged by the regulator not to meet its standards or regulations, the Provider will be expected, upon request, to share with the Commissioners any action plan they have put in place to meet the regulators requirements and the Commissioners may, in their absolute discretion, deem this failure to meet standards and regulations to be a material breach of contract.  Providers must meet the requirements detailed in the Department of Health Code of Practice on the prevention and control of infections related guidance published Dec 2010, Health and Social Care Act 2012, NICE Infection Control guidelines (2014) and Nursing and Midwifery Council Clinical Codes of Conduct.  This document will be reviewed annually and information concerning any changes will be circulated to all Providers.  Providers are expected to deliver End of Life Care (EOLC) and will be guided by the National End of Life Care Strategy, quality markers for EOLC and the Social Care Framework for EOLC. They will develop a policy (“EOLC Policy”) and a plan (“EOLC Plan”) covering each stage of EOLC pathway. Providers shall provide a copy of their EOLC Policy and EOLC Plan to Commissioners. They are expected to ensure Individuals (or their nominated representative) are as fully involved as possible in making choices and decisions, and fully document needs and communicate with others involved in the Individual’s care.  This contract covers Cambridgeshire and Peterborough CCG registered patients. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   | **Domain 1** | **Preventing people from dying prematurely** | **** | | --- | --- | --- | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **** | | **Domain 4** | **Ensuring people have a positive experience of care** | **** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **** |   **The Provider must comply with:**   * **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)** * **Care Quality Commission (Registration) Regulations 2009 (Part 4)**   **2.2 Local defined outcomes**  The key service outcomes below are based on the NHS Outcomes Framework[[1]](#endnote-2) and Adult Social Care Outcomes Framework[[2]](#endnote-3):   * People with care and support needs have an enhanced quality of life. * People have a positive experience of care and support. * People are helped to recover from episodes of ill health or following injury. * People are treated and cared for in a safe environment and protected from avoidable harm * People are treated to minimise pain, discomfort and anxiety, whilst maximising quality of life * Health-related quality of life for people with long-term conditions * Enhancing quality of life for people with mental illness * Enhancing quality of life for people with dementia * Reducing time spent in hospital by people with long-term conditions * Proportion of people feeling supported to manage their condition * Patient safety incidents reported * Proportion of people who use services to have control over their daily life |
| **3. Scope** |
| **3.1 Aims and objectives of service**  The service objective is to deliver care in a Care Home with Nursing environment for those Service Users, that are the full funding responsibility of the NHS or who have needs that meet the eligibility criteria for NHS Funded Nursing Care. The provider shall deliver an appropriate level of care as defined in the Individual’s Care Plan and accommodation to ensure that the Service Users health and social care needs are met within the regulatory requirements of the Care Quality Commission.  The service will be provided for people (Service Users) who have been determined by the Commissioner as having NHS-funded continuing healthcare or Funded Nursing Care entitlement.  The Provider will ensure that the services can be provided 365 days per year, 24 hours a day and in accordance with a Service User’s Care Plan.  The aim is to commission care that is of a high quality and is person-centered, working with Care Providers who comply with the fundamental standards for quality and safety and who are pro-active in continuously improving the services they provide. As part of this service, Care Workers are expected to look beyond the commissioned tasks and consider what assistance the Service User requires to leave them safe, comfortable and in a clean environment.  **3.2 Service description/care pathway**  Eligibility for NHS funded continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.  Consideration of primary health need includes consideration of the characteristics of need and their impact on the care required to manage them. In particular, to determine whether the quantity and quality of care is more than the limits of responsibilities of Local Authorities, consideration is given to the following:   * Nature and type of need * Intensity * Complexity * Unpredictability of need   The applicant for CHC funding, including a ‘fast track’ patient, will have had their eligibility assessed and agreed in accordance with the current National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care.  NHS continuing healthcare may be provided in any setting (including, but not limited to, a care home, hospice or the person’s own home). Eligibility for NHS continuing healthcare is, therefore, not determined or influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care. The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS continuing healthcare eligibility.  End of Life Care (EoLC) is not a separate Service User group but where required is part of the care given for all Service User groups.  **The services provided shall include the quality of care covered by the NHS Funded Nursing Care contribution.**  **3.3 Service User/Care Groups covered**   * Adults (Age 18 and over)/Older Peoples Residential/Nursing * Acquired Brain Injury * Physical Disability * Learning Disabilities * Respite Care * Adults/Older Peoples Mental Health Care * Dementia Care * End of Life Care   **3.4 Any acceptance and exclusion criteria and thresholds**  This contract includes:   * Patients eligible to Continuing Healthcare funding (CHC) * Patients eligible to Funded Nursing Care (FNC)   This contract excludes:   * Care Homes without Nursing Care * Forensic Care * Community based care (e.g. Home Based Care) * Care Homes for those under 18 years old * Acute and Community NHS Hospitals   **3.5 Interdependence with other services/providers**  The Services should be seen as part of wider integrated adult health and social care services working in partnership with GPs, Primary Health Care teams, acute providers, local authorities, community mental health teams, the voluntary sector, community, faith and independent sector providers.  The Provider must demonstrate how it will work with these other organisations to support individuals and their Carers to successfully manage the individuals’ need for support. They should as a minimum have a well-developed and audited pathway for communication with commissioners, GPs and the wider health, voluntary and social services environment.  The Provider shall communicate with the CHC team in relation to a patient’s condition, change in care needs including improvement. The Provider will be expected to engage in the review process, MDT discussions and DST. To establish a full overview of a patient’s condition and presentation the Provider will supply all relevant upto date information prior to a review sent via secure email. The Provider will also communicate with the CHC Team to work with families and patients to achieve best outcomes. |
| **4. Service Delivery** |
| **4.1 Choice of Home**  4.1.1 Admission to a Care Home  Patients registered with a Cambridgeshire and Peterborough General Practitioner for whom the CCG has agreed meet the eligibility criteria for fully funded health care will be referred to the provider by the CCG for assessment of suitability against the Provider’s admission criteria. An assessment by the Provider should be completed within 24 hours of a referral being made, 5 days a week or where possible accept the Trusted Assessor assessment. The expectation is that this will be 6 days a week in the second year of the contract. The admission to the care home should take place within 24 hours of the assessment. There will always be exceptions that will be agreed as long as the care home provides a reasonable explanation.  Some patients may already be resident and will only require a transfer of funding responsibility from the date the CCG determines the patient meets the eligibility criteria for fully/partially funded healthcare. The Provider should complete and submit a checklist for a decision on CHC/FNC eligibility to funding.    An introductory visit for individuals, their families or friends shall be facilitated where requested and take place prior to assessment whenever practical.  Requests for CHC eligible admissions may arrive from several areas including – community (patient at home), transfer form Nursing home to new provider, out of area transfer, existing patient within the home (i.e FNC) or in some cases a patient deemed CHC eligible whilst in the Acute environment.  The Provider will ensure each Service User is to be accommodated in their own single room unless they request otherwise and this is agreed with the Commissioner.  4.1.2 Needs Assessment  New patients are admitted based on a full assessment being undertaken by people trained to do so, and to which the prospective Service User, his/her representatives (if any) and relevant professionals have been party.  The Provider will be notified that a patient is required to transfer to the home via CHC Brokerage.  The Provider is required to complete an assessment or where possible use the Trusted Assessor assessment and agree transfer suitability within 24 hours of receipt of written information from the Commissioner. The assessment should consider factors including clinical presentation, suitable environment, staffing levels and skill set of care team. Also giving consideration of needs of other residents.  Following admission the Provider will develop within 24 hours an Individual care plan and associated risk assessment with the patient and family where appropriate, with a full “person centred” care plan to be completed within 7 days of admission and sent to the Complex Cases Management Team via [capccg.chc@nhs.net](mailto:capccg.chc@nhs.net).  The Commissioners will review the provision of social and nursing care within 3 months of admission followed by an annual review, as minimum. Where, during the period of stay a significant change in the level of nursing care needs occurs for an individual patient, the provider shall inform the Commissioner. A re-assessment of the individual’s care needs shall then be undertaken by the CCG.  4.1.3 Service User needs  The Level of Need will be determined through MDT discussion and referenced in the DST. The CCG and Provider will refer to the Clinical indicators document, see Appendix 1, to agree the Tier assignment based on the clinical presentation as described in the document. This will be agreed prior to admission.  In agreeing to a care package the Provider is expected to meet all the Service User needs included in the care package.  The Care Plan is a living document. The Commissioner will be responsible for identifying the Service User’s care needs and developing an initial plan for the needs to be met. The Provider will review, edit and develop the Care Plan and its contents will be reviewed on an on-going basis. The Provider will maintain a record of Care Plan reviews.  4.1.4 Person-centered care  The Care Plan person-centered contents:   * Record the Patient’s needs and the corresponding Provider requirements to meet those needs * Record the Patient’s preferences, as informed by the Care Consultant or life story tolls eg “patient passport” * Include a description of the Patient’s personal outcomes for the care package * Include any relevant deprivation of liberty (DoL) statement or mental capacity statement.   Indicative activities to support Patients in achieving the required outcomes are also detailed in Appendix 2.  **4.2 Advocates**  The Provider will:   * Support the Service user to use Advocates, where appropriate * Have links to local advocacy services where available * Make a referral to an independent Advocate when a conflict arises in the Service User’s life and the Service User has no family or Carers, or is particularly frail or vulnerable. In these instances, the Provider will also notify the Commissioner * Inform any Advocate representing a Service User of major changes in the Service User’s life.   **4.3 Carers**  The Commissioner has a duty of care to the Service User’s Carers as per the Care Act 2014. As part of the Service the Provider will:   * Work cooperatively with Carers to deliver care to the Service User * Meet the support needs of Carers as agreed in the Care Plan * Provide Guidance to Carers, including referring Carers to the Local Authority or local carers’ organisation, as required.   **4.4 Visitors**  The Service User’s relatives and friends are able to visit without being unnecessarily restricted. The Service User can refuse to see a visitor and the Provider will support the decision.  The Provider will not permit any persons to enter the Service User’s room without the Service User’s knowledge and permission, except in cases of emergency.  The Provider will agree visiting guidelines with the Service User, Carers and family upon commencement of care. The Provider will maintain a signing in and out system for all visitors.  **4.5 Service User possessions**  All references to the Service User below also refer to Carers where appropriate.  4.5.1 General  The Provider will comply-  Care Workers will not:   * solicit or accept any gratuity, tip, or any form of money taking or reward, collection or charge for the provision of any part of the Services, other that the payment as agreed under the contract * accept any gift of cash or vouchers and any other gift over the value of £25. All gifts will be reported to the Provider for approval. The Provider will report any concerns regarding the acceptance of gifts to the Commissioner and appropriate authorities such as CQC/Local Authority if required * become involved with the making of the Service User’s will or with soliciting any form of bequest or legacy * agree to act as a witness or executor of the Service User’s will * become involved with any other legal document, except in circumstances pre-agreed with the Commissioner * offer or give advice to the Service User with respect to investments or personal matters.   4.5.2 Property  Care Workers will respect the fact that the care environment is the Service User’s home. Care Workers will be sensitive to that environment and its contents.  Care Worker will not:   * consume the Service User’s food or drink without appropriate permission or invitation * use the Service User’s possessions e.g. computer or telephone * use furniture or possessions in a way that the Service User would not want * take responsibility for looking after valuables on behalf of the Service User.   Any loss of or damage to the Service User’s property should be immediately reported to the Service User. In the event that Care Workers are responsible for damage or loss the Provider will be responsible for compensating the Service User.  The Service User’s possessions will only be disposed of with the permission of the Service User.  4.5.3 Equipment  The Provider will provide and maintain any equipment appropriate to meet the needs of the Individual either through their equipment suppliers or a GP if on FP10, at no additional cost to the Commissioner. The provider will ensure that all staff are trained in the use of equipment as appropriate.  If following a clinical review, it is identified that the Individual requires bespoke equipment, the Provider must contact the Commissioner to discuss and agree purchasing arrangements prior to supply. Purchasing arrangements must be agreed in writing by the Provider and the Commissioner, failing which the Commissioner shall not be liable for the cost.  4.5.4 Equipment provided by the Commissioner  The Commissioner expects the Provider to provide all necessary equipment for Patients that have been accepted against the Provider’s admission criteria.  The Commissioner will only consider requests to pay for specific equipment where a Service User’s needs have substantially changed during their placement and are bespoke in nature. Requests will be considered based on the Individual’s needs, by the Commissioner  In the exceptional event that equipment is provided for the Individual by the Commissioner it must be:   * Managed safely and securely; * Operated in line with the manufacturer’s instructions; * Made available for maintenance; and * Only used in relation to the named Individual.   In the event of the equipment no longer being required for the Individual for whom the equipment was identified, the Provider must advise the Commissioner within 24 hours (or first working week day) in order that arrangements can be made and agreed for the equipment’s collection.  **4.6 On-going care**  4.6.1 Care Plan Review  The objective of the Care Plan review is to check that the care package meets the Service User needs and outcomes. The Care Plan review incorporates input from the Service User, Service User’s family and Carers. The consent of the Care Plan will be reviewed and amended as necessary. Where changes are made, the updates will be shared with the Commissioner.  The Provider will review as a minimum the Care Plan:   * Every six months * At the request of the Service User, Carers, family, Commissioner or Care Worker * As Service user changing needs require it * As prompted by an incident or complaint   Where there is a significant change in needs, i.e. clinical determination requiring increased intervention, the Provider will notify the Commissioner in writing to enable a joint discussion on agreed intervention and management plan. This may also include transfer of care setting where it is recognised that the patient’s clinical needs may no longer be met in the home. The Provider will work with the Commissioner, patient ad family to ensure that the patient is kept safe until suitable alternative care can be arranged.  If a patient’s condition improves the expectation is that the Provider will also notify the Commissioner to enable a review of care to be undertaken to ensure eligibility criteria is maintained.  Where the MDT decision determines that the eligibility criteria is no longer upheld The Provider will work with the Commissioner to ensure that the Responsible Commissioner of Care transfer process is engaged. In some cases, it is with recognition that the patient may be deemed to be the commissioner of care (self-funder).  The Provider will work with the Commissioner and Local Authority to ensure that a transfer of care provider where required is timely and all parties are engaged to ensure that the patient is transferred to an appropriate care setting. This includes sharing of information to new providers for example.  4.6.2 Additional Needs  If a patient requires additional support during care (in exceptional circumstances only), the Provider will obtain written agreement from the Commissioner in advance of the additional support being put in place. Authorisation will be sought in writing, supported by evidence and a clinical rationale and must be for an agreed fixed duration. Please email [capccg.chc@nhs.net](mailto:capccg.chc@nhs.net) for authorisation.  The Commissioner will not be liable for the cost of additional care that was not agreed in advance.  In situation where urgent additional care is required for a rapidly deteriorating Service User, where it is not possible to seek advance agreement from the Commissioner, authorisation will be sought the next working day. The Provider may be asked to provide evidence of the emergency or sudden significant change.  Where a patient’s presentation changes and requires intense care interventions, 1:1 support will be considered as part of a short term plan. In exceptional cases where patient safety is compromised a maximum of 16 hours will be considered. The Commissioner considers that 8 hours of a 24 hour period Service Users will have core clinical intervention and supervision.  A regular record of dependence and behaviour will be required as per schedule 6A – Reporting Requirements of the contract.  **4.7 Medicines management**  The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) requires that organisations establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner and in accordance with Cambridgeshire and Peterborough CCG’s Medicines Standards for Providers. See separate standards document in the contract schedules.  The Provider will have a clearly written policy for the management of medicines (“Medicines Management Policy”) which is in accordance and adheres to the Cambridgeshire and Peterborough CCG Medicines Standards and also the following current national guidance,   * Current NICE guidelines * Managing Medicines in Care Homes: The Royal Pharmaceutical Society of Great Britain (2014) * Professional advice documents produced by CQC (including but not limited to administration of Medicines in Care Homes, medicine administration records In Care Homes and Domiciliary Care, the Safe management of Controlled Drugs in Care Homes etc.) * The Misuse of Drugs Act 1971 (amended). The Medicines Act 1968 and the Human Medicines Regulations 2012 and any subsequent amendments * Nursing and Midwifery Council (NMC) standards for Medicines Management and administration of medicines.   The Provider is responsible for ensuring that all staff adhere to the policy, associated standards etc and all individuals resident in the Care Home (Nursing and Residential homes with nursing) receive a review of medications by the GP every 6 months or more frequently as required.  **4.8 Infection Control**  The Provider will:   * Have evidence based policies and procedures in place reflecting Public Health England/Health Protection, Department of Health, NICE and Royal College of Nursing guidance for standard infection prevention and control * Co-operate with and support screening procedures, in particular for Individuals at high risk of contracting healthcare associated infections, e.g. Individuals who will need hospital admissions because of chronic conditions, are going to be having surgery or have pressure sores or leg ulcers * Work effectively with other organisations to reduce the risk of healthcare associated infections (for instance, when transferring an Individual with methicillin-resistant staphylococcus aureus (MRSA) between a hospital and the Care Home (Nursing)) * Work with the NHS Infection Control Nurse and/or the Health Protection Agency to undertake root cause analysis of all healthcare associated infections and take action to prevent further incidences.   **4.10 Transport and Escorts**  Transport   * The cost for organised trips and outings will be met within the agreed weekly fee * The cost of personal transportation for non-NHS trips and outings are not covered by this contract and are not the Commissioners’ responsibility. * In circumstances where a change of accommodation is agreed and the patient does not meet the eligibility criteria for Non-Emergency Patient Transport the cost should be agreed with the patient, family and the Providers.   Escorts  The Provider will arrange appropriate transport for Individuals attending secondary and tertiary care service appointments and appointments with other statutory authorities regarding assessed care needs. The Provider should liaise with the appointment provider regarding return transportation.  For patients, not already receiving 1 to 1, escorting to planned hospital appointments or other essential appointments the Provider will not be required to accompany patients. Where required, arrangements can be made in advance with the Transport Provider and receiving Service to meet the needs of the Service User.  **4.11 Planned and Unplanned Absences**  4.11.1 General Principles  Where the patient is hospitalised and expected to return to the nursing home, the patient’s placement with the Provider will remain open to the patient for a period of two weeks on hospital admission – this is the standard retention period. Full payment of at the usual rate will be made for the standard retention period but any additional care such as 1 to 1 will not be paid. However, in circumstances where it can be identified at admission or early on that returning to the placement is not suitable the Provider is to discuss with the Commission reducing the termination period in order for the Provider to release the bed. The Provider must inform the Commissioner by telephone on the day of admission/absence.  Once the standard or extended retention period has expired, the placement will cease and the Provider will, with the agreement of the Commissioner, contact the patient’s representatives so they can collect the patient’s personal effects. No further payment will be made following the agreed standard or extended retention period. Where there are no representatives for a patient, the Provider will follow legal requirements and any established procedures in order for the necessary arrangements to be made for removing the patient’s possessions.  Where a reassessment of the patient is necessary prior to returning to the care home, the Provider will conduct this within 24 hours (or next working day) of the patient being declared “medically stable” or accept the Trusted Assessor assessment.  The Commissioner may negotiate the extension of the Individual’s placement longer than the standard six week retention period as required and any extension must be in writing.  4.11.2 Accessing Unscheduled care / avoiding unnecessary admission to hospital  Where clinically appropriate, before a call is made to the GP / Out of Hours /111 service the person-in-charge should assess the need for the call.  Where clinically appropriate, before a call is made to the ambulance service (unless a medical emergency) an attempt should be made to discuss the request with the GP / Out of Hours service/111/JET service. The person-in-charge should make both calls.  4.11.3 Activity supporting Individual admission into hospital  If possible an Individual should be escorted to hospital by a member of staff or if an ambulance has been called a handover to ambulance staff should be made.  The provider will ensure that a document, e.g. “This is Me” document, containing an Individual’s healthcare needs including diagnosis, medications and all relevant data accompanies the Individual to hospital.  Upon admission into hospital or another provider the Provider will inform:   * + the Individual’s next of kin/ a named representative as soon as possible;   + the Commissioner verbally and via email/letter within 24 hours;   + the Individual’s GP within 24 hours; and   + in addition the Provider shall provide a written Transfer of Care and/ or Body Map to hospital and maintain a copy for their own records   + The Provider will maintain daily contact with the hospital throughout the patient’s stay   .  4.11.4 Activity supporting Individual discharge from hospital  Prior to the Individual’s discharge from hospital the Provider will review the patient’s clinical needs and confirm in writing they accept the patient returning to the placement.  If the Provider can continue to meet the patient’s needs, upon re-admission to the Care Home (Nursing) the Provider will inform:   * + the patient’s next of kin/ a named representative of the re-admission as soon as possible;   + the Commissioner of the re-admission verbally/email/in writing within 24 hours;   + the Commissioner of any revisions to the Care Plan within 48 hours of re-admission; and   + the Commissioner and CQC of any changes to the Transfer of Care and/ or Body Map since admission.   In exceptional circumstances where the Provider can no longer meet the clinical needs of the patient the Provider must inform the CHC Team via [capccg.chc@nhs.net](mailto:capccg.chc@nhs.net) within 4 hours of readmission.  4.11.5 Planned trips / Holiday / Agreed extended leave without Provider Staff  An Individual may take a planned trip / holiday / agreed leave and go out of the home (for instance, with family and friends).  On these occasions the Provider will:   * Complete a risk assessment in conjunction with the Individual (and the person or persons accompanying them) prior to the outing. The risk assessment should address the care the Individual should receive (including timely administration of medication) and when the Individual is due to return to the Home * Agree the risk assessment with the Commissioner in advance of the period of leave; and negotiate a retention period and rate with the Commissioner as required via [capccg.chc@nhs.net](mailto:capccg.chc@nhs.net)   4.11.6 Unplanned absence/absconsion  If an Individual does not return to the Care Home (Nursing) as planned following agreed leave, the Provider will try to contact the Individual and those accompanying them to establish if there is a problem. If the Individual cannot be contacted, the Provider should instigate escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert, and also follow the Missing Persons Protocol.  If the Individual leaves the Care Home (Nursing) without notifying the Provider, the Provider should instigate escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert.  The Provider will notify the Commissioner of the unplanned absence within 24 hours.  The Provider will adhere to the reporting requirement for Individuals receiving care under any section of the Mental Health act as appropriate.  The Provider will hold the Individual’s room for a period of seven days which the Commissioner will fund. If the Individual does not return within seven days the individual placement will cease unless the Commissioner and Provider negotiate an extended retention period. The patient’s belongings will be placed in storage and the next of kin contacted to arrange collection within 28 days at which point the belongings will be disposed of.  **4.12 Death**  In the event of the death of a Patient, the Provider must comply with Care Quality Commission (Registration) Regulations 2009 (Part 4), regulation 16 notification of death. The Provider will also notify:   * the Patient’s next of kin/a named representative as soon as is reasonably practicable, so that suitable arrangements (including burial/cremation) can be made; * The commissioner via email to [capccg.chc@nhs.net](mailto:capccg.chc@nhs.net) on the first working day after death * the Patient’s GP within 48 hours * The Provider will ensure that the patient’s medicines are retained for a period of seven days in case there is a coroner’s inquest.   The Provider will at all times treat carers/relatives sensitively and with privacy and dignity. The Provider will ensure that the Patient’s medicines are managed in accordance with CQC Essential Standards. In the cases of a suspicious death the Provider will notify the Commissioner as soon as is reasonably practicable.  The Commissioner will pay for up to 2 days after the confirmed date of death.   * 1. **Discharge**   In the event of a planned discharge the Commissioner will pay up to the day of discharge.  **4.13.1 Patients no longer eligible for NHS CHC**  If the patient is no longer eligible for NHS CHC, 7 days’ notice will be given to the Provider. The Local Authority will be notified to undertake an individual assessment.   * + 1. **Notice Periods for Individual Patients**   Where the Commissioner gives notice:   * In the event of a safeguarding or patient safety issue, the Commissioner may transfer a patient or patients to another Provider without notice to the Provider. In these circumstances, Commissioners will not be liable for any further payment from the date of discharge. * In all other circumstances, if the Commissioner decides to transfer a patient to another Provider, the Commissioner will provide minimum 7 days’ notice of such transfer in writing or e-mail to the Provider. * In the event the Commissioner transfers the patient to another Provider prior to the end of the Transfer Notice Period: The Provider shall receive payment, for the transferred patient for the period up to the end of the notice period. * If the Commissioner is unable to safely transfer the patient before the end of the notice period, a further period will be applied to the date of transfer at the earliest opportunity. The NHS CHC Team shall regularly update the Provider regarding the anticipated date of transfer. * In the event that the patient, their representative, family or Carer informs the Provider that he or she wishes to change their care provision, the Provider must inform the NHS CHC Team.   Where the Provider gives notice:   * If the Provider wishes to give notice to the Commissioner regarding a patient, a minimum of 7 days’ notice shall be given in writing via the NHS CHC Team and the patient, their representative, family or carer. * If the Commissioner is unable to safely transfer the patient before the end of the notice period, the Provider shall continue to provide the Services to the patient until such time as the Commissioner transfers the patient. The Provider shall be paid for each day in excess of the notice period that the Provider provides Services to the patient. The NHS CHC Team shall regularly update the Provider regarding the anticipated date of transfer. * Where the Provider wishes to give notice on provision of Services to three or more patients, an extended notice period will be agreed in order that safe and appropriate alternative placements may be sourced. The period of notice will be agreed between the Commissioner and Provider or as defined in the NHS Standard Contract.   **4.14 Staffing**  **4.14.1 Staff Recruitment, Retention, Training and Management**  Staff are recruited, trained, and supervised in a manner, which ensures consistently high standards for Patients*.* The provider has a clear policy and procedures in relation to staff recruitment, induction and ongoing supervision.  The provider shall operate a staff recruitment and selection procedure based on equal opportunities which takes all reasonable steps to ensure that individuals employed are in all respects appropriate persons to work with vulnerable people.  The provider shall require applicants to complete an appropriate application form which includes full employment history including any gaps in employment and the reasons why. The provider will have two written references including, where applicable, a reference relating to the person’s last period of employment which involved working with children or vulnerable adults of not less than three months’ duration.  The provider shall ensure that an enhanced Disclosure and Barring Service check is undertaken for all staff within the home (including volunteers) prior to commencing duties and a copy of the result is kept on file.  Trained staff NMC pin numbers are checked prior to employment by the Provider and on an annual basis thereafter and evidence of revalidation records are maintained.  The ratios of care staff to Patients must be determined according to the assessed needs of Patients, and a system operated for calculating staff numbers required, in accordance with guidance as defined in Registered Homes Act, 1984 or via the use of researched skill mix and number tools be permitted i.e. NMC (Rhys Hern 1970) Cambridgeshire Health Authority Minimum staffing notice Section 23 (3), RCN Directive  **4.14.2 Staff Competence, Training and Supervision**  Patients enjoy the benefit of professionally trained and competent staff providing care and support.  The care home staff training and development programme meets National Training Organisation (NTO) workforce training targets/national training certificate standards and ensures staff fulfil the aims of the home and meet the changing needs of Patients.  All members of staff receive induction training to NTO specification within 6 weeks of appointment to their posts, including training on the principles of care, safe working practices, the organisation and worker role, the experiences and particular needs of the Service User group, and the influences and particular requirements of the service setting  The provider ensures that there is a staff training and development programme, which meets the Skills for Care standard and NMC of the Code -Professional standards of practice and behaviour for nurses and midwives  Indicators: of competence training and supervision include:   * A learning culture exists within the home. * The provider has a clear policy and procedure for induction and training. * Staff display the confidence of competent work practices. * Areas of specialist training are provided to staff when necessary. * Registered nurses are facilitated in fulfilling their professional statutory requirements for updating to maintain their registration with the NMC. * Managers and providers display a commitment to ensuring consistency in work practices and quality care. * The provider shall ensure that all care staff receive regular supervision at least 6 times per year under their policy and procedure for appraisal.   **4.15 Management and Administration**  4.15.1 Day to Day Operations/Ethos  Patients live in a home that is well run and managed by a person who is fit to be in charge, of good character and able to discharge his or her responsibilities fully.  Patients benefit from the ethos, leadership and management approach of the home.  The Care Home Manager shall have the skills, leadership and competence to effectively manage the home on a daily basis.  The Care Home manager has at least 2 years’ experience in a senior management capacity in the managing of a relevant care setting within the past five years; nursing care is provided by the home the manager has a relevant management qualification and current clinical qualification or has a clinical lead or deputy with a current clinical qualification.  The Care Home Manager shall maintain personal and professional competence in line with current practice and will ensure they delegate appropriately with clear lines of accountability.  4.15.2 Quality Assurance  Continuous quality improvements systems are in place to ensure the home is run in the best interest of the Patients for the provision of nursing care.  The provider has quality assurance and monitoring systems in place, based upon seeking the views of Patients, to measure success in meeting the aims, objectives and statement of purpose of the home. This information is made available to the Commissioner as defined in the Contract schedules.  Providers are required to assist the Commissioner in evaluating the quality of effectiveness, not only of the care to the individual Service User but also contract compliance.  Indicators of good quality assurance are:   * Services are provided having been subject to audit and evaluation processes. * Communications should be robust and appropriate to Patient’s needs. * Quality assurance and improvement will be supported by staff appraisals, clinical supervision and individual learning needs analysis. * The significance of audit processes in improving quality is recognised by Patients, relations and friends. * Quality services are recognised as a motivating force and staff strive for continuous improvement.   4.15.3 Record Keeping  The Patients health, personal and social care needs are set out in an individual plan of care which they have actively been involved in preparing and which includes their wishes.  Patients benefit from records that demonstrate effective communications which support and inform high quality care, are shared with patients and relatives and demonstrate treating people with dignity and respect.  Individual records and home records are secure, up to date and in good order; and are constructed, maintained and used in accordance with the Data Protection Act 1998 and other statutory requirements.  Security and confidentiality is safeguarded through explicit measures.  All Care plans and medical notes are made available on request to the Continuing Care / Funded Nursing Care Assessor/CCG.  **4.16 Key Areas for Trained Nurse**   * Clinical skills * Team Work * Personal/Professional Development * Accountability * Management * Research & Evidence Based Practice * Clinical Leadership * Training/mentorship * Clinical supervision * The 6 C’s: Care, Compassion, Competence, Communication, Courage and Commitment. (Department of Health Dec 2012) * Clinical Governance   The following skills listed under each area are indicative, not exhaustive.[[3]](#footnote-2)  4.16.1 **Clinical Skills**  Venepuncture  Ear Care  Female & Male Catheterisation  Suprapubic Catheterisation  Care & management of Syringe Drivers  Wound Management  Leg Ulcer Management  Nutritional Care including PEG  Mentoring of Students  End of Life Care  4.16.2 Team Work  Effective & appropriate communication with a variety of staff, and other agencies i.e. GP’s  Effective management of workloads  Team working  4.16.3 Personal & Professional Development  Responsibility for own professional development  Practices and participates in clinical supervision and personal reflection  Update with mandatory & statutory training through own organisation  Committed to continuing own learning beyond registration  Practices evidence based practice  Aware of organisations agendas and that of health service  The NMC Code, Standards of conduct, performance & ethics for nurses and midwives  4.16.4 Accountability  Individuals practice in line with the NMC Code  Demonstrates accountability and responsibility and how to apply it to their nursing practice  Acknowledge own limitations but take steps to remedy any deficits  Patients interests are always safeguarded and issues reported and discussed with line manager/matron  4.16.5 Management  Able to perform full holistic assessment and record this assessment  Be financially aware i.e. of cost of wound dressings and continence products and use best practice  4.16.6 Research & Evidence  ***Understand and practice evidence based practice***  Evidence based practice is an approach to making quality decisions and providing nursing care based upon personal clinical expertise in combination with the most current, relevant research available on the topic. Evidence based practice implements the most up to date methods of providing care, which have been proven through appraisal of high quality studies and statistically significant research findings and NICE guidance.  4.16.7 Clinical leadership  Clinicians have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction.  4.16.8 Training and Mentorship  Training and Mentorship is defined as a professional relationship in which an experienced person (the trainer/mentor) assists another (the trainee/mentee) in developing specific skills and knowledge that will enhance the less experienced person’s professional and personal growth.  4.16.9 Clinical supervision  An activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. Clinical supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues (1996).  The Six Cs   * Care * Compassion * Competence * Communication * Courage * Commitment |
| **5. Applicable Service Standards** |
| **5.1 Applicable national standards (eg NICE)**  The Care Standards Act 2000 made provision for the creation of a registration authority, an independent non-government public body, to regulate social and health care services previously regulated by local councils and health authorities. The Care Standards Act 2000 and its regulations set out a broad range of powers covering, amongst other matters, the management, staff, premises and conduct of social care establishments.  The Health and Social Care Act 2001 (Section 49) removes local authority responsibility for funding nursing care with effect from 1st April 2003 for Patients entitled to local authority support and with effect from 1st October 2001 for clients who were previously self-funding in nursing care.  The Disability Discrimination Act 2005 brings in rights and measures, which are aimed at ending the discrimination which many disabled people face.  ‘No Secrets’ Multi-Agency Adult Protection Policy 2008 and the Care Act 2014    **Compliance with the Mental Capacity Act (MCA 2005), incorporating Deprivation of Liberty Safeguards (DoLS 2007)**  **-** The MCA/DOLS legislation provides a statutory framework for decision making regarding patients who may lack capacity to consent or make decisions for themselves.  - Failure to comply with the MCA/DOLS legislation denies patients of their right of choice and involvement, which is central to quality improvement and patient experience  - The MCA introduces a criminal offence of ill-treatment and wilful neglect of a person  who lacks capacity, which practitioners could be liable to  - The NICE (2018) guideline (108) on Decision-Making and Mental Capacity reinforces  the ethos of the principles upon which the MCA/DOLS legislation is based and offers  a step-by-step guide to its implementation.    - Deprivation of Liberty Safeguards (DOLS) are based on Article 5 of the European  Convention on Human Rights (ECHR), which confers the right to liberty    - It is illegal to deprive someone of their liberty unless authorised by due legal  process and for those who reside in care homes, DOLS authorisation is processed by  the relevant Local Authority  - NHS England mandates CCGs to ensure that the services that are commissioned on  behalf of the population it serves are compliant with MCA/DOLS legislation  - As Commissioners, we should seek evidence of an embedded cultural shift within  Provider Organisations which reflect that rights of patients and compliance with  the Act are being recognised and actioned within care planning, guidance and training    Health and Safety Legislation including:   * Management of Health and Safety at Work Regulations 1999 * Manual Handling Operations Regulations 1992 * Control of Substances Hazardous to Health Regulations 2002 (COSHH) * Reporting of Injuries, Diseases and dangerous occurrences Regulations 1995 (RIDDOR)   Any person who manages a care home providing nursing care is registered with the Care Quality Commission (CQC) in accordance with the Care Standards Act 2000 Section 23 (1). This person is required to comply with all requirements of the Care Standards Act 2000 and its regulations.  All nursing staff will be registered with the Nursing and Midwifery Council a regulatory professional body. In line with Health Service Guidance (95) 21, any practitioner supplementary to medicine (i.e. occupational therapist, physiotherapist, orthoptist, dietician, chiropodist) employed by the provider must be state registered practitioners and appropriate checks are undertaken prior to employment (e.g. DBS check).    This Specification applies the full legislation contained in these Acts and Regulations, which should be referred to in full.  Any reference in this document to any statutory provision includes any modification, re-enactment or replacement of it.  Providers should adhere to the following guidance from NICE, including but not limited to:   * + NICE CG161 – Falls: assessment and prevention of falls in older people   + NICE SC1 – Managing medicines in care homes   + NICE CG176 – Head Injury Guidance   + NICE NG 48 – Oral Health for Adults in Care Homes   Definitions of Pressure Ulcers grades will be in line with the guidance issued by the NPUAP – Pressure Injury Stages (2016)[[4]](#footnote-3)   * + Stage 1 Pressure Injury: Non-blanchable erythema of intact skin   + Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis   + Stage 3 Pressure Injury: Full-thickness skin loss   + Stage 4 Pressure Injury: Full-thickness skin loss and tissue loss   + Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss   + Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration.   **5.2 Applicable standards set out in Guidance and/or issued by a competent body**  Care Quality Commission (CQC) ‘Fundamental Standards’[[5]](#footnote-4). These are the standards everyone has a right to expect when they receive care.  Providers are expected to provide Nursing Care to evidence based standards, which are in line with the Nursing Midwifery Council ‘The Code Professional Standards of Practice and Behaviour’.  **5.3 Applicable local standards**  The Commissioner and Provider agree to adhere to the local multi-agency policy and procedures on adult protection.  References: -   * + - ‘A Better Home Life – A Code of Good Practice for Residential and Nursing Home Care’ (1996);     - Care Homes Regulations 2001 and National Minimum Standards 2000;     - Framework for Nursing Care, Evaluation and Development;     - Guidelines for Good Practice on the Use of Restraint in Residential and Nursing Homes for Adults;     - NHS Funded Nursing Care Practice Guidance (December 2018);     - Essence of Care 2010 (Department of Health);     - Nursing Midwifery Council – The Code Professional Standards of Practice and Behaviour     - Care Quality Commission * National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (Department of Health, October 2018 Revised); * National Service Framework older people 2001 (Department of Health); * The Food Safety and Hygiene (England) Regulations 2013   Where additional resource is required (eg 1:1 care) to meet a patient’s needs. This will be met by the Provider and not sub-contracted via an agency. |
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| **7. Individual Service User Placement** |
| The contract price payable by the Commissioner to the Provider for the provision of Residential Care Services shall be the sum specified in Section 3A Local Prices of the NHS Standard Contract.  The Provider and the Commissioner acknowledge that in some circumstances an Individual or a third party acting on behalf of the Individual may choose to pay additional contributions in order for an Individual to stay in more expensive accommodation in the Care Home (Nursing) than the Commissioner considers that Individual requires. In such circumstances the Provider shall enter into a separate third party agreement with the Individual or the third party as appropriate (providing a copy to the Commissioner) and collect such agreed additional contributions from the Individual or third party directly.  For the avoidance of doubt the Commissioner shall not be liable to pay any additional contributions which are detailed in the agreement between the Individual or a third party acting on behalf of the Individual and the Provider. The CCG will pay for services relating to the assessed clinical needs as detailed in the agreed care plan. Service users should never be requested to pay for any service relating to clinical needs or charged for NHS care as this would contravene the founding principles and legislation of the NHS. Further guidance can be found section 270 – 278.  Access to NHS services depends upon clinical need, not ability to pay. The CCG will not charge a fee or require a co-payment from any NHS patient in relation to the assessed needs. The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006. The CCG is not able to allow personal top up payments into the package of healthcare, where the additional payment relates to core services assessed as meeting the needs of the individual and covered by the fee negotiated with the service provider (e.g. the care home) as part of the contract.  However, where service providers offer additional services (Lifestyle Choice) which are unrelated to the person’s identified health care needs, the person may choose to use personal funds to take advantage of these services.  Examples of such services falling outside NHS provision include hairdressing, enhanced TV package, Wi-Fi, share of enhanced facilities pool, gym, library, garden room, difference for an enhanced room over and above the standard accommodation the CCG pays for. Any additional services which are unrelated to the person's primary healthcare needs will not be funded by the CCG as these are services over and above those which the service user has been assessed as requiring, and the NHS could not therefore reasonably be expected to fund those elements.  The provider will only be able to invoice the CCG for the care costs and reasonable accommodation costs associated with the person’s primary healthcare needs and will have to contract with and invoice the client separately for any services unrelated to those needs. The CCG will require a copy of the contract with the patient detailing/itemising what is being charged for sent by secure email (encrypted and password protected to [capccg.chc@nhs.net](mailto:capccg.chc@nhs.net)). |

**Service Specification 02 – Domiciliary Care**

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| **Service Specification No.** | Domiciliary Care 02 |
| **Home Care (Domiciliary Care) Service** |  |
| **Commissioner Lead** |  |
|  |  |
| **Period** | 1st April 2021 – 31st March 2022 |
| **Date of Review** | 1st April 2022 or as required following mandated regulation |

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| Population NeedsFor population by commissioner |
| National/local context and evidence base In this context, Home Care (Domiciliary Care) refers to care for people living in their own homes. The person is visited at various times of the day or, in some cases, care is provided over a full 24-hour period. The needs of people using the services may vary greatly and packages of care are designed to meet individual circumstances. Where there is good quality care, provided throughout the day, the person may live independently of any continuous support or care between the visits[[6]](#footnote-5).  The Service Specification covers commissioning of specialist and non-specialist Home Care (Domiciliary Care) services by CCGs for NHS CHC Service Users; however this document may be useful in commissioning for Service Users including those who are jointly funded with the Local Authority, S117 and ad hoc placements.  A growing number of Service Users wish to remain within their own homes. Supporting Service Users within their own homes promotes community-based, person-centered care and choice. |
| 2. Outcomes |
| 2.1 NHS Outcomes Framework Domains & Indicators  | **Domain 1** | **Preventing people from dying prematurely** |  | | --- | --- | --- | | **Domain 2** | **Enhancing quality of life for with long-term conditions in accordance with person-centered care plans, including any end of life plans** |  | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** |  | | **Domain 4** | **Ensuring people have a positive experience of care** |  | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** |  |  2.2 Local defined outcomes The key service outcomes below are based on the NHS Outcomes Framework[[7]](#footnote-6) and Adult Social Care Outcomes Framework[[8]](#footnote-7).  • People with care and support needs have an enhanced quality of life.  • People have a positive experience of care and support.  • People are helped to recover from episodes of ill health or following injury.  • People are treated and cared for in a safe environment and protected from avoidable harm  • People are treated to minimise pain, discomfort and anxiety, whilst maximising quality of life  • Health-related quality of life for people with long-term conditions  • Enhancing quality of life for people with mental illness  • Enhancing quality of life for people with dementia  • Reducing time spent in hospital by people with long-term conditions  • Proportion of people feeling supported to manage their condition  • Patient safety incidents reported  • Proportion of people who use services to have control over their daily life  Performance indicators for the outcomes are outlined in Schedule 4 of the Particulars. The outcomes depend on other services that are complementary to Domiciliary Care services in some cases. The Provider should work co-operatively with the relevant services to meet outcomes.  **2.3 Individual’s Outcomes**  Consider people around Personal Health Budgets (PHB) and how outcomes could be linked to PHB and support ploan. Starting point would be the outcomes defined in the care plan. |
| 3. Scope |
| 3.1 Aims and objectives of service The service will be provided for people (Service Users) who have been determined by the Commissioner as having an adult NHS-funded continuing healthcare entitlement.  The Provider will ensure that the services can be provided 365 days per year, 24 hours a day and in accordance with a Service User’s Care Plan.The CCG commission care that is of a high quality and is person-centered, working with Care Providers who comply with the fundamental standards for quality and safety and who are pro-active in continuously improving the services they provide. As part of this service, Care Workers are expected to look beyond the commissioned tasks and consider what assistance the Service User requires to leave them safe, comfortable and in a clean environment.  The objective of the service is personalised care that is safe and promotes a good quality of life, meets assessed needs and contributes to the outcomes identified for each individual Service User. Also to contribute to the reduction of inappropriate hospital admissions where patients have expressed a wish to be cared for within their own home.  The aim of the service is to deliver Domiciliary Care that:   * puts the health, safety, quality of life and preferences of the Service User at the centre of care provision; * supports the Service User to make informed choices about their care, as per the NHS Constitution; * supports the health, safety and quality of life of Carers as outlined by the Care Act and National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care[[9]](#footnote-8); * meets the outcomes outlined in section 2 through effective working partnerships; * strives to continuously improve the quality of care for the Service User; and * provides continuity of care for the Service User, wherever possible. * explanation and apology from Providers when services are not delivered to plan * care Workers that arrive on time, carry out the commissioned activities, interact with Service Users and stay for the full time that is set out in the Service Users care plan * that two Care Workers arrive together on time when this is required * that Care Workers have the required skills to meet their needs, including for Service Users receiving end of life care * that the care provided is carried out in a way that shows an understanding of and a concern for the Service Users and their family’s emotional wellbeing   Receiving NHS Continuing Healthcare Funded Domiciliary Care should not automatically be seen as being longterm and Service Users will be subject to ongoing review to determine whether the care packages still meet their needs. It is expected that a number of care packages will reduce. 3.2 Service description/care pathway Eligibility for NHS funded continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.  Consideration of primary health need includes consideration of the characteristics of need and their impact on the care required to manage them. In particular to determine whether the quantity and quality of care is more than the limits of responsibilities of Local Authorities, consideration is given to the following:   * Nature and type of need * Intensity * Complexity * Unpredictability of need   The applicant for CHC funding, including a ‘fast track’ patient, will have had their eligibility assessed and agreed in accordance with the current National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care.  NHS continuing healthcare may be provided in any setting (including, but not limited to, a care home, hospice or the person’s own home). Eligibility for NHS continuing healthcare is, therefore, not determined or influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care. The decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need, such that the active management of this need is reduced or no longer required, will this have a bearing on NHS continuing healthcare eligibility.  End of Life Care (EoLC) is not a separate Service User group but where required is part of the care given for all Service User groups. 3.3 Population covered The Service Specifications describe the Domiciliary Care services provided to adults (over 18 years of age) who have been assessed as eligible for NHS Continuing Healthcare. This service is for any patient registered with a Cambridgeshire and Peterborough GP Practice.  Any other individual for whom the CCG has a responsibility to commission care. 3.4 Any acceptance and exclusion criteria and thresholds The purpose of the Decision Support Tool (DST) is to support the application of the National Framework and inform consistent decision making. The DST should be used in conjunction with the guidance on the National Framework for NHS Continuing Healthcare.  The DST should be completed by a multidisciplinary team (MDT) which will be inclusive of Service User, their representatives and current care staff from the Provider, following a comprehensive multidisciplinary assessment of an individual’s health and social care needs and their desired outcomes. The DST is not an assessment in itself.  MDTs are then asked to make a recommendation as to whether the individual should be entitled to NHS continuing healthcare.  This service does not apply to individuals who are presently living in NHS funded or self-funded residential and/or nursing care. 3.5 Interdependence with other services/providers The Services are part of wider integrated adult health and social care services. The Provider and Commissioner will work in partnership with GPs, primary healthcare teams, acute providers, Local Authorities, community mental health teams, the voluntary and community sector, and independent providers (this is not an exhaustive list).  Contact with relevant services will vary according to the needs identified in each Service User’s specific case. The Provider shall co-ordinate all relevant services such as medical, specialist nursing, social services, chiropody, primary care services and ensures relevant and accurate communication is maintained. The Service shall be integrated into the end of life care pathway adopted by the Clinical Commissioning Group.  The Provider shall ensure that Service User referrals to primary and community care are made in a timely manner and are followed up when a referral is not accepted or actioned.  The Provider shall advise the Commissioner at any point that it appears that a Service User may require an advocacy service, or an Independent Mental Capacity Advocate. The Provider shall give all reasonable assistance and cooperation to the advocacy service or Independent Mental Capacity Advocate appointed in respect of any Service User including access to all information held in regard of that Service User and access to that Service User at all times. |
| 4. Applicable Service Standards |
| 4.1 Eligibility The Commissioner will ensure the CCG will assess the Service User’s care package and if there has been a change in need their eligibility via an MDT process at three months after initially being deemed eligible and at a minimum, annually thereafter. The Service User will be asked if they want family, Carers or Advocates to attend the assessment and outcome discussion.  If, as a result of the assessment, the Service User no longer meets the eligibility criteria for Continuing Healthcare the Commissioner will formally notify the individual and the Local Authority in order if required for a needs assessment and (where applicable) a carer's assessment to be conducted.  Care may have been commissioned whilst a patient is on a discharge to assess (D2A) pathway from hospital. This care is funded for up to 6 weeks until eligibility for CHC is established. 4.2 Service User needs In agreeing to a care package the Provider is agreeing to provide a care package to meet the assessed needs of the Service User.  The Care Plan is a living document. The Commissioner will be responsible for identifying the Service User’s care needs and developing an initial health care plan for the health care needs to be met. The Provider will review, edit and develop the Care Plan to meet the identified needs and submit to CHC within 7 days of accepting the Service User. The efficacy of the Care Plan and its contents will be reviewed on an on-going basis. The Provider will maintain a record of Care Plan reviews and submit to the Commissioner at the 3 month review. 4.2.1 Care and Support Plan Contents4.2.2 Medical contents The Care Plan medical contents:   * include the Service User’s diagnosis summary and relevant medical history; * record the Service User’s medication, and administration details for medication, including the dosage and frequency * include clear instructions on medication management, i.e. prompt the Service User, administer * are informed by discharge documents and mobilisation plans (e.g. transport, equipment, continence) and existing medicines administration records (MAR).  4.2.3 Person-centered contents The Care Plan person-centred contents:   * record the Service User’s needs and the corresponding Provider requirements to meet those needs; * record the Service User’s preferences, as informed by the Care Consultation or life story tools e.g. “patient passport”; * include a description of the Service User’s personal outcomes for the care package; and * include any relevant deprivation of liberty (DoL) statement or mental capacity statement.  4.2.4 Carer related contents The Care Plan includes the roles and needs of any Carers associated with the care package. 4.2.5 Risk Assessment record The Care Plan includes a Risk Assessment record of risks to the Service User, Carers, Care Workers and others persons associated with the care package. Risks may include (but are not limited to):   * risks from the care environment; * safeguarding risks; * risks related to Service User behaviour; and * risks assessments for nutrition (Malnutrition Universal Screening Tool – MUST), pressure ulcers, falls etc.   The Risk Assessment record also includes any specific requirements for managing and mitigating risks. 4.2.6 End of Life Care (EoLC) The Care Plan includes Advance Care Plans and Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs)/Advance Decision to Refuse Treatment (ADRTs) where applicable. This is in line with ReSPECT. 4.2.7 Additional care The Provider will notify the Commissioner and agree additional care in advance, any revision of funding will occur 28 days post notification. The Commissioner will not be liable for the cost of additional care that was not agreed in advance.  Additionally should there be a reduction required in a care package the care provider is to notify the CCG within 24 hours. If the notification is not received by the CCG, the CCG reserves the right to review appropriate time sheets and invoices as claimed for by the provider. If it is noted that the provider has claimed for work not undertaken then the CCG will claim the funding back.  In situations where urgent additional care is required for a rapidly deteriorating Service User but there is insufficient time for advanced agreement, the Commissioner will cover the cost of the care. The Provider will notify the Commissioner by phone call and follow up by confirmation email by the next working day. Such situations include emergencies or sudden significant changes in the Service User’s condition. The Provider will be asked to provide evidence of the emergency or sudden significant change.  Any deviations from the NHS Standard Contract Terms & Conditions will be agreed in advance and documented in either a Contract Variation notice. The agreement, including any variations, will be reviewed as part of the Service Users review. 4.2.8. Contact details The Care Plan includes contact information for family, Carers and Advocates in case of emergency.  **4.2.9. NHS email encryption system**  The Provider must ensure adherence to registering and using NHS mail  The Provider will ensure there are always sufficient staff that are suitably trained and available to access and acknowledge receipt of all secure emails within one operational day of the email being sent by the Commissioner. 4.3 Care Package The Provider will agree to deliver a care package in which every Service User will receive an individual, person-centered care package that is within the scope of the services that the Provider can deliver. The appropriateness of the care package will be decided by the Commissioner, informed by input from the MDT and the Provider.  If the Provider fails to deliver the care commissioned, payment will be withheld. 4.4 Cooperating with healthcare professionals and other providers The Provider will:   * ensure the Service User has access to the full range of primary healthcare services via their GP. The Provider will refer the Service User to their GP in a timely manner; * enable the Service User to access secondary and tertiary care service appointments, including accompaniment appropriate to the level of risk and care need associated with the activity undertaken by the Service User; and * alert the appointment provider of any Service User interpretation and communication requirements prior to the appointment.   Service Users are intended to have appropriate access to other primary and community health services commissioned by the Commissioner; where any difficulty is experienced in arranging such access for a Service User, the Provider will raise this with the Commissioner, so that the latter can seek to resolve the issue. 4.5 Care Worker continuity The Provider will maximise Care Worker continuity wherever possible. 4.6 Care Tiers Service User needs vary widely and the services shall deliver care as defined within the defined Care Tier And in accordance with an agreed care plan clearly identifying care needs and interventiosn required. This should also details length of calls and frequency.  See appendix 2. 4.7 Advocates The Provider will:   * support the Service User to use Advocates, where appropriate; * have links to local advocacy services where available; * notify the Commissioner should a conflict arises in the Service User’s life and the Service User has no family or Carers for a referral to an independent Advocate,  4.8 Informal Carers The Commissioner has a duty of care to the Service User’s Informal Carers as per the Care Act 2014. As part of the Services the Provider will:   * work cooperatively with Carers to deliver care to the Service User; * meet the support needs of Carers as agreed in the Care Plan; and * provide Guidance to Carers, including referring Carers to the Local Authority or local carers’ organisation, as required.  4.9 Visitors The Service User’s relatives and friends are able to visit without being unnecessarily restricted. The Service User can refuse to see a visitor in their own home, and the Provider will support this decision.  The Provider will not permit any persons to enter the Service User’s home without the Service User’s knowledge and permission, except in cases of emergency.  The Provider will agree visiting preferences with the Service User, Carers and family upon commencement of care. 4.10 Service User’s home The Provider is responsible for ensuring a safe working environment for Care Workers. As part of the Risk Assessment, the Provider will minimise and mitigate risks. The Provider will enable Care Workers to make informed choices about risks.  In cases where the Service User’s home is not smoke-free, the Provider will take steps to minimise Care Workers’ exposure to smoke. Additionally Care Workers may choose not to work in a smoking environment and the Provider will support this decision without penalty.  Where the Service User’s home compromises the ability to deliver safe and appropriate care the Provider will report this to the Commissioner. 4.11 Service User possessions All references to the Service User below also refer to Carers where appropriate. 4.11.1 General The Provider will comply:  Care Workers will not:   * solicit or accept any gratuity, tip, or any form of money taking or reward, collection or charge for the provision of any part of the Services, other than the payment as agreed under the contract; * accept any gift, monetary or otherwise. All gifts will be reported to the Provider for approval. The Provider will report any concerns regarding the acceptance of gifts to the Commissioner; * become involved with the making of the Service User’s will or with soliciting any form of bequest or legacy; * agree to act as a witness or executor of the Service User’s will; * become involved with any other legal document, except in circumstances pre-agreed with the Commissioner; * offer or give advice to the Service User with respect to investments or personal financial matters.   **4.11.2 Care Worker Conduct & Performance**  If a Care Worker is repeatedly late to a care session, the Service Provider will consider replacement of the Care Worker as long as this is not to the detriment of the Service User’s.The CCG will undertake audits as per the Quality Reporting Requirements within the year.  If the Care Worker does not attend a care session, the session will not be paid for by the Commissioner. 4.12 Property Care Workers will respect the fact that the care environment is the Service User’s home. Care Workers will be sensitive to that environment and its contents.  Care Workers will not:   * consume the Service User’s food or drink without appropriate permission or invitation; * use the Service User’s possessions e.g. computer or telephone; * use furniture or possessions in a way that the Service User would not want; and * take responsibility for looking after any valuables on behalf of the Service User.   Any loss of or damage to the Service User’s property should be immediately reported to the Service User. In the event that Care Workers are responsible for damage or loss the Provider will be responsible for compensating the Service User.  The Service User’s possessions will only be disposed of with the permission of the Service User. Where the Service User’s home compromises the ability to deliver safe and appropriate care the Provider will report this to the Commissioner. Equipment For all Equipment funded by the Commissioner, the Provider will use equipment only for its intended purpose and in relation to the named Service User. 4.13.1 Provider supplied equipment The Provider will supply as to COSHH- personal protective equipment and ensure:   * Suitability for the conditions of the job * Ensue it offers the right level of protection     The equipment will be supplied at no additional cost to the Commissioner. The cost of the equipment will be built into the cost of care. This equipment will include:   * single use disposable gloves; * single use disposable aprons; and * eye protection * alcohol hand rub.   The Provider will safely and appropriately dispose of the above items and clinical waste in the Service User’s home. 4.13.2 Commissioner supplied Equipment All specialist equipment specified in the Care and Support Plan will be supplied and funded by or via the Commissioner.  If the Service User requires further specialist equipment, the Provider must contact the Commissioner to discuss purchasing arrangements prior to supply.  The Provider will:   * check if Equipment needs to be maintained/serviced; * arrange required maintenance/servicing or alert the Commissioner to this need; and * not be responsible for the cost of maintenance * notify the Commisioner of Service User death so that the appropriate arrangements can be made to collect the equipment   If the Provider has mistreated or adapted equipment in any way the Provider will be liable for the replacement cost, cost of repairs and/or any other incurred costs. Mistreatment includes but is not limited to unauthorised removal or use of Equipment for another person. 4.14 Medication The Provider will:   * agree policies and procedures for medicine management with relevant CCG Medicines Management teams; * seek information and advice from a pharmacist regarding medicines policies (including the management of over the counter medicines and alternative medicines); * store medicines correctly in the Service User’s home, dispose of them safely * not control Service Users’ behaviour with inappropriate use of medicines, * not give medicines prescribed for individual Service Users to any other person.   The Provider’s medicines management policies will:   * include procedures for achieving the Service User’s preferences and ensuring that the Service User’s needs are met, in accordance with regulation; * include clear procedures for giving medicines   The Provider will seek information and advice from the pharmacist, where appropriate, in relation to administering, monitoring and reviewing medication.  The Provider will ensure that Service Users’ medication is reviewed with their General Practitioner six monthly or more frequently as required.  . 4.15 Records management In addition to the Care Plan and the complaints log, the Provider will maintain the following records. 4.16 Service User Guide The Provider will make the Service User Guide available and accessible to the Service User. The Service User Guide as a minimum includes:   * the Provider’s complaints and feedback procedures; * contact details for the Provider (including out of hours); * contact details for the CQC; * Service User rights and Provider obligations; * Care Worker procedures and policies; * safeguarding contact details for LA; * NHS Commissioner contact details; and * explanation of how personal information will be used  4.16.1 Care activity log The care activity log details, in English, the delivery of the Care Plan through all care provided to the Service User during each care visit. This record is standardised and includes as a minimum:   * the date and time care was provided; * the type and frequency of care provided; * any relevant observations; * any actions to be taken and the name of the person responsible; and * the signatures of the Care Workers providing the care.   The Provider will complete the care activity log each occasion that care is delivered. A Provider supervisor or manager will review the care activity log as required. 4.16.2 Care Worker training log The Care Worker training log records of all qualifications, training and induction sessions received by Care Workers. Records will show the date training was completed, any relevant evidence, and the signature of the trainer confirming that the training was completed satisfactorily. The Provider will complete the Care Worker training log as per the quality dashboard requirements and share it with the Commissioner as requested. Care Workers must be trained to deliver the support tasks required, with the list of all appropriate training specified in the training log.  In order to safeguard the health, safety and welfare of Service Users, the Provider must ensure at all times there are sufficient members of staff with the appropriate competencies, knowledge, qualifications, skills and experience to meet the needs of the people who use the service. The Provider will ensure that there is a staff mix that reflects the needs of this Contract and the levels of experience of the Care Workers should at least be consistent with the CQC National Standards. This includes the provision of a Registered Manager who is aware of and meets the requirements of the duties and responsibilities of a Registered Manager under these standards.  The competency of care staff employed is the responsibility of the Registered Manager and should be maintained by regular participation in training, personal development activities and supervision.    The Provider will ensure all staff undertake and successfully complete an induction programme for Care Workers, which incorporates the Care Certificate and its standards. Care Workers must not work alone with Service Users until they have successfully completed the Provider’s staff induction programme. All staff shall receive initial and on-going training in relation to the specific assessed needs of the Service User.  All staff shall receive initial and on-going training in relation to the specific assessed needs of the Service User e.g. End of Life Care, Dementia care, Mouth care, Skin care, Catheter care, Safeguarding, Infection Prevention Control, Confidentiality, Basic Life Support etc. This list is not exhaustive.  In the case of End of Life Care, all staff will have received the appropriate training in how to care for the Service User and be responsive to the family of Service Users who are rapidly approaching the end of their life.  The Provider will ensure continuity of care and Care Worker to the Service User whenever this is possible. The Provider will also ensure that whenever regular care workers who are already known to the Service User are unable to attend they will inform the Service User and their family of such a change. The Provider is responsible for ensuring the replacement Care Worker is fully aware of any specific routines and preferences contained within the care plan. Replacement carers should have been introduced to the Service User and their family before they work alone with that Service User for the first time. The Provider will ensure that care workers are provided with appropriate items of Personal Protective Equipment (PPE) to promote good infection control standards and to comply with Health and Safety requirements of the tasks they will be expected to perform under this contract. This may include but is not limited to disposable gloves and aprons. Any representative of the Provider who visits a Service User’s home shall wear a form of photographic identification that shows their name and the name of the Provider. 4.16.3 Incident log The Provider will comply with the NHS Contract Service Conditions and maintain a record of all Patient Safety Incidents (PSIs). The Provider will notify the Commissioner of all PSIs as soon as is reasonably practicable. This notification will include actions taken by the Provider to mitigate further harm. The Provider and the Commissioner will develop an action plan to prevent further PSIs.  **4.16.4 Safeguarding**  The provider must report safeguarding concerns via the protocols agreed by the Commissioner.  **4.16.5 Challenging** **Behaviour**  Challenging behaviour must be considered in the context of the environment in which it occurs, the way the Service is organised and the needs of the Service User.  The Provider shall have a policy to positively engage and support Service Users who show challenging behaviour. This policy will take account of all relevant legislation and guidance and good practice. The policy should be regularly reviewed to ensure it conforms to all current legislation and good practice. All behaviour monitoring forms should be submitted to the complex cases team weekly.  Provider staff shall demonstrate a consistent response to any continuing behaviour of a disruptive nature. The Provider shall be aware of and shall have plans for known challenging behaviour in the Service User’s Care Plan.  It is not acceptable to use any form of restraint, verbal abuse or isolation as punishment for challenging behaviour.  The Provider shall take all reasonable endeavours to mitigate Service User removal from the package. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Removal of the placement will only occur if all other demonstrable efforts to resolve issues have been unsuccessful.  **4.16.6 24 Hour Service**  In some cases there may be a need for the provision of 24-hour care. The 24-hour service is likely to include the personal care tasks list in the above categories. In addition, the Provider will comply with the following provisions:   * The Provider shall ensure that their staff provide their own food and drink whilst on duty, and shall not use the Service User’s supplies. However staff may, with the consent of the Service User, make use of food and drink preparation equipment.   The Provider will be responsible for covering the breaks required and the CCG will only22 hours of the 24 hour care service.  4.1**6.7 Sleeping and Waking Nights**  In certain circumstances, there may be a requirement for the provision of a night service to ensure the needs of particularly frail or vulnerable Service Users are met and /or to support carers. The requirements for these services will be identified during assessment and will be outlined in the Care and Support plan. Depending on the needs of the Service User and/or their carer, the night service may require the staff member to remain awake throughout the night or to sleep and only be disturbed as and when assistance is required.  The night care service is likely to include the personal care tasks listed in the above categories. In addition, this may require the staff member to remain in the same room as the Service User to ensure his/her specific needs are met throughout the night. A sleeping night means a caer may be disturbed up to twice a night for assistance with personal care needs  A full description of these services is in Appendix 1. |
| 5. Processes |
| 5.1.1 Referral acceptance By accepting the referral, the Provider confirms that they can meet the Service User’s needs. If the Provider cannot meet the Service User’s needs, they must reject the referral. The Provider may also reject the referral in accordance with clauses within the NHS Contractual Service Conditions. 5.1.2 IPA agreement In principle, the price for delivery of the service is set out in the IPA and not in the service specification. The IPA can then either describe which care package the service user is receiving (and which agreed price therefore applies) or, if necessary, describe a bespoke package and price. 5.1.5 Transfer to Provider The Provider will assign a named Provider representative to the Service User. The Provider representative’s contact details will be provided to relevant partners (e.g. the Commissioner’s CHC team, District Nurse, GP).  The Commissioner’s CHC team will be notified by the Provider of any changes to the discharge arrangements and receive written confirmation on the day the Services commence. 5.2 Commencement of care5.2.1 GP registration The Provider will check that the Service User is registered with a local GP upon commencement of care. Where the Service User is not registered with a local GP the Provider will inform the Commissioner within 30 calendar days.  **5.2.2 Care Worker introduction**  A Provider representative who has met the Service User will introduce Care Workers to the Service User. Where care packages are to commence within 24 hours as detailed in section 5.1.2 this may not be possible.  A qualified Provider representative will supervise the initial delivery of care. 5.2.3 Service User Guide and Care Plan At the commencement of care, the Provider will review the Service User Guide and Care Plan with the Service User and Service User’s family and Carers. The care plan and associated risk assessments will be completed within 48hrs of the care commencment  The Provider will make the Service User Guide available and accessible to the Service User. The Service User Guide as a minimum includes:   * the Provider’s complaints and feedback procedures; * contact details for the Provider (including out of hours); * contact details for the CQC; * Service User rights and Provider obligations; * Care Worker procedures and policies; * safeguarding contact details for LA; * NHS Commissioner contact details; and * explanation of how personal information will be used   As part of the Service User Guide and Care Plan review, the Provider will:   * provide a welcome pack about the service in an accessible format, including but not limited to the following information: a statement of the aims and objectives of the services provided, how the Provider operates on a day to day basis, how the service user may contact the manager. * provide a statement that the Provider does not discriminate on the grounds of race, gender, disability, age, sexual orientation, religion or belief, either in service delivery or recruitment of staff. * detail any additional services to those described within this specification offered by the Provider. * make the Care Plan available in a format that the Service User can understand; request the Service User or their representative to sign the Care Plan; the frequency of re-assessment of the Care Plan * leave a copy of the Care Plan with the Service User unless there are clear and recorded reasons not to do so; * give instructions on how to use the Service User Guide; * explain how feedback can be submitted; * check that the Service Users, and Service User’s family and Carers have confidence in the Provider’s procedures for collecting and acting on feedback; and * provide an outline of the Provider’s process around patient death, including the processing time and any associated costs   Information should be available in appropriate languages, jargon free and readily understandable by the Service User. 5.2.4 Initial care plan Care Workers and a qualified Provider representative will conduct an initial review within the 48 hours of care commencement. The initial review assesses the suitability of the care package to meet the needs of the Service User.  The Care Plan will be adjusted to reflect the changes from the initial review. All changes will be agreed by the Service User and Service User’s family or Carers. The Provider will communicate proposed significant changes to the Commissioner in writing. The Commissioner will review the proposed changes and implement clinical review, where appropriate. All significant changes must be authorised by the Commissioner in writing and funding changes adopted after 28 days from notification. 5.3 On-going care5.3.1 Care Plan review The objective of the Care Plan review is to check that the care package meets the Service User needs and outcomes. The Care Plan review incorporates input from the Service User, Service User’s family and Carers. The content of the Care Plan will be reviewed and amended as necessary. Where changes are made, the updates will be shared with the Commissioner.  Significant Changes to the Care Plan will be confirmed with the Commissioner before implementation, as per initial review (section 5.2.4). If the Provider changes the care package without explicit, written consent from the Commissioner, the Provider will be solely liable for any additional costs incurred.  The Provider will review as a minimum the Care Plan:   * as Service User changing needs require it; or * every six months; * at the request of the Service User, Carers, family, Commissioner, or Care Worker; * as prompted by an incident or complaint.  5.3.3 Resuscitation and medical emergencies If a Care Worker identifies a medical emergency (this can include but is not limited to suspected heart attacks, significant falls, or overdoses) they will call an ambulance.  Where Care Workers are qualified and confident in the undertaking, they should administer CPR when appropriate, being mindful of applicable DNACPRs/ADRTs.  Providers should ensure that all care workers follow internal escalation processes and escalate to appropriate care manager  Following this, the Provider will contact the Service User’s family or advocate. The Provider should report the outcome to the Commissioner as soon as is reasonably practicable. 5.3.4.2 Interruption to care – Provider default The Provider is responsible for informing the Commissioner when care has not been delivered. In these cases, the Provider will provide an explanation; this may lead to formal action on the part of the Commissioner.  The Commissioner will not be liable for the cost of planned care that was not delivered due to Provider fault. The Provider is responsible for accurate invoicing. 5.3.4.3 Interruption to care – no Provider default Where the Provider receives more than 24 hours’ notice no payment will be made for interruptions to care for reasons outside the Provider’s control. In these instances, the Provider will inform the Commissioner.  Additionally no payment will be made if the Provider could reasonably have known that care would not take place (e.g. following Service User hospitalisation or death).  Where an interruption to planned care is beyond the control of the Provider, and the Provider has not received 24 hours’ notice, the Commissioner may pay the cost of care for that day, but not for subsequent days. 5.3.5 Activities outside the Service User’s own home The Provider will support the Service User to participate in activities of the Service User’s choosing, accompanying the Service User as required during the hours defined within the Care Plan.  5.3.5.1 Transport and Travel  In order to promote person centered solutions to transport which maximise independence, choice and control, the Provider is required to support the Service User to make arrangements to meet their transport and travel requirements to and from hospital visits, however there is also the Hospital Travel Costs Scheme, under which Service Users can recover costs. A variety of transport and travel methods should be considered by the Provider in supporting suitable and safe transport. 5.3.6 Refusal of care The Service User may decline or refuse care or participate in activities that prevent the delivery of care if they have the mental capacity to do so. The Provider will respect the Service User’s right to make these decisions. Where the Service User has detrioriation or is lacking mental capacity to make an informed decision to either give or refuse consent to care, a decision must be made in the Service User’s ‘best interests’. The best interests decision should be recorded5.3.7 Hospital stays **5.3.7.1 Payments during unplanned hospital stay**  The Service User’s care package with the Provider will remain open to the Service User for a period of up to 7 days on admission to hospital. The Commissioner will consider a negotiation of a reduced funding agreement (IPA) if carers cannot be temporarily reallocated to another care package whilst the Service User is in hospital.  Payment during planned hospital stay  The Service User’s care package with the Provider will remain open to the Service User for a period of 1 day admission to hospital. The Commissioner will consider a negotiation of a reduced funding agreement (IPA) if carers cannot be temporarily reallocated to another care package whilst the Service User is in hospital. The Provider will cease to provide the Services to the Service User during the Service User’s hospital stay, unless agreed otherwise with the Commissioner in advance.  Upon admission into hospital the Provider will inform:   * the Service User’s family or Carers within 24 hours; * the Commissioner verbally or by email within 24 hours; and * the Service User’s GP within 24 hours  5.3.7.2 Activities supporting hospital discharge At the invitation of the Commissioner, the Provider will review the Service User’s needs to ensure they can still be met by the Provider, prior to the Service User’s discharge from hospital. If the Provider can continue to meet the Service User’s needs the Provider will agree any necessary revisions to the Care Plan with the Commissioner. The Provider will, as far as is practical and reasonable, maintain continuity of Care Workers.  In circumstances where the Provider can no longer meet the needs of the Service User, the Provider will notify the Commissioner and Service User as soon as possible explaining the rationale for no longer being able to care for the Service User. Then work with the Commissioner and Service User to source an alternative provision of care. 5.3.8 Discharge from care The Service User will be discharged from care in accordance with the NHS Contractual Service Conditions.  Note: where the Service User is transferred from the Provider to a new Provider the outgoing Provider will produce and share a Care Transfer Plan.  The Service User will not be discharged from care without prior approval from the Commissioner. All reasonable efforts will be made to prevent termination of the care package. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Termination of the care package will only occur if all other demonstrable efforts to resolve issues have been unsuccessful.  If, despite all reasonable endeavours to resolve issues, the Provider cannot meet the Service User’s needs then the Provider and Commissioner will work to discharge the Service User to a service that can meet their needs in accordance with the NHS Contractual Service Conditions. 5.3.9 Service User death The Provider will maintain and operate a Death of a Service User Policy as per NHS Contractual Service Conditions.  Where the Provider is notified of the death of the Service User, the notification will serve as effective notice of discharge from care under section 5.3.8. |
| 6. Care Worker Management |
| 6.1 General The Provider will:   * ensure that Care Workers understand their responsibilities and are aware of standards; * schedule Care Workers’ work to provide continuity and fairness in the timing and duration of tasks; * enable Care Workers to raise concerns, and action those concerns; and * have a clear, written description of Care Worker roles and decision-making ability regarding the care of a Service User. |

**Appendix 1**

**Live-in care / 24 hour live in care / sleeping night care**

**and waking night care**

**1. Definition of the Service**

## Delivery of Live-In Care / 24 hour Live in Care /sleeping night care and waking night care services shall comply with the requirements of The Home Care Services Specification (Schedule 2) and with the additional requirements of this appendix.

## It includes the range of care and support services provided by Care Worker(s) living or staying on the Service Users’ premises for extended periods.

## The Service will provide support and care to enable Service Users to remain in their own home, individually or with their own family, partner or friends.

# 2. Scope of the Service

## The service will be available to adults in the Cambrdigeshire and Peterborpugh CCG population who have been assessed as meeting the eligibility criteria, needing community care services and intensive live in care/24 hours live in care or sleeping and waking night care services.

# 3. Services to be provided

## This Service will be delivered in accordance with the Home Care Services Specification and Conditions of Contract.

**Ongoing Live In Care**

1. Live in Care is where the carer or carers live within the Service User’s residence for agreed periods and meet the identified needs as described within the agreed care plan, but not providing waking night support.
2. Carer Worker(s) also have agreed time off during the day. The Care Worker(s) is expected to be available and “on-call” during the night and can be called once or twice at night for a short period. This however should be reviewed should it become a regular event for extended periods.
3. The Provider will ensure that continuous and adequate care and cover is provided, using the same Care Worker(s) whenever possible to ensure continuity of care.

## Short term 24 hour Live-in Care

## 24 hour Live in Care differs from live in care in that the package is for a short term only. The Care Worker(s) live within the Service User’s residence for agreed periods and meet the identified needs as described within the agreed care plan, but not providing waking night support.

1. The Provider will ensure that continuous and adequate care and cover is provided as required including coverage of the Care Worker(s) time off and breaks.

## Sleeping Night Care

1. Where a sleep-in or on-call service is commissioned by the CCG, the Provider will provide a Care Worker(s) to work 9 hours usually between 10.00pm and 7.00am.
2. The Care Worker(s) should be able to use a separate bedroom in the Service User’s home. If this is not possible, the Provider will supply a portable bed for use in the living area.
3. The Provider is responsible for ensuring that bedding is available and laundered at no additional inconvenience or cost to the Service User.
4. The Care Worker(s) may be called once or twice during the night for limited periods. If night time support occurs on a regular basis this will be reviewed by the CCG and the Provider.

## Waking Night Care

a) Where a waking night service is commissioned by the CCG, the Provider will provide a Care Worker(s) to work 9 hours usually between the hours of 10.00pm and 7.00am.b) The Care Worker(s) will remain awake throughout the night and perform any such duties as may be needed by the Service User and/or specified on the care plan.

**4. Principles and Values**

1. Service Users have the right to be alone or undisturbed. Workers should enable Service Users to retain privacy within their homes with due regard to the Service User’s wishes.
2. Care Worker(s) must ensure care tasks are carried out in private.
3. If working within a family environment, the Care Worker(s) must take due regard to minimise the disturbance to normal family life and relationships.
4. If working within households with children, the worker must be clear of the parental relationships and responsibilities and not impede these in any way.
5. The Care Worker(s) should be briefed and trained in the correct use of the Service User’s property and equipment.
6. As the Service User’s home is the temporary or semi-permanent home of the Care Worker(s), sharing space and allowing for periods of solitude are important for both the Service User and the Care Worker(s), if required.
7. The provider must ensure that for any live in care arrangement that the Care Worker(s) is provided with food. The Service User will not be expected to contribute towards the cost of food for live in Care Worker(s).
8. The Care Worker(s) may be required to accompany the Service User when attending day or social opportunities to assist with agreed tasks such as personal care or enabling.
9. The Provider must ensure the Care Worker(s) will be enabled to be off-duty for at least two hours each day. Any off duty periods are to be mutually agreed between the Provider, Service User and Care Worker(s).

**SCHEDULE 2 – THE SERVICES**

1. **Indicative Activity Plan**

**Not Applicable**

1. **Essential Services (NHS Trusts only)**

| **Not Applicable** |
| --- |

1. **Other Local Agreements, Policies and Procedures**

|  |  |  |
| --- | --- | --- |
| **Policy** | **Data** | **Weblink** |
| Business Continuity Management Policy |  | If not already done so please upload to Adam. |
| Complaints  Policy |  | Please upload to Adam |
| Duty of Candour Policy |  | Please upload to Adam |
| Clinical Policies | As published to the  Website <http://www.cambsphn.nhs.uk/Home.aspx> | Polices may be reviewed and developed at any time during the year and if that is the case, commissioners and providers are notified of such policies and are required to implement the policies within the required timescales.  All CCG clinical policies are available and will be updated on the following web site:  <http://www.cambsphn.nhs.uk/CCPF.aspx> |
| Clinical Thresholds |  |  |
| Code of Conduct for Trust Visits | October /November 2016 |  |
| Invoicing Details |  | Will automatically be completed through provisions on Adam CMS |
| Prescribing Framework | November 2017 |  |

1. **Transfer of and Discharge from Care Protocols**

|  |
| --- |

1. **Safeguarding Policies and Mental Capacity Act Policies**

|  |
| --- |

# SCHEDULE 3 – PAYMENT

1. **Local Prices**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Cambridgeshire & Peterborough CCG - Indicative Rates April 2021**  **The Adam DPS will enable the CCG and Providers to have greater confidence that the prices agreed for care packages will be the market rate. To assist providers to respond to package offers, the CCG is sharing below indicative prices, which are based on the prices agreed for care packages, for each Care Tier, since 1st September 2020.** | | | | |
|  | **Cambridge City; East Cambridgeshire; South Cambridgeshire** | | **Fenland; Huntingdonshire; Peterborough** | |
| Care Tier 1  Care Tier 2  Care Tier 3 | Care Home  £/week  900  1,050  1,250 | Domiciliary Care  £/hr  20.00  21.50  22.50 | Care Home  £/week  850  1,000  1,200 | Domiciliary Care  £/hr  19.50  21.00  22.00 |

1. **Local Variations**

*For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by NHS Improvement (available at:* *[www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices](http://www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices)) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.*

| **Not Applicable** |
| --- |

1. **Local Modifications**

*For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by NHS Improvement (available at:* [*www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices*](http://www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices)*). For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets*.

| **Not Applicable** |
| --- |

**D. Expected Annual Contract Values**

| Not Applicable |
| --- |

# SCHEDULE 4 – QUALITY REQUIREMENTS

1. **Operational Standards and National Quality Requirements**

\*Greyed out areas are not applicable

| **Ref** | **Operational Standards/National Quality Requirements** | **Threshold** | **Guidance on definition** | **Period over which the Standard / Requirement is to be achieved** | **Applicable Service Category** |
| --- | --- | --- | --- | --- | --- |
| 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% | See Diagnostics Definitions and Diagnostics FAQs at: <https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/> | Month | CS  D |
| E.B.S.3 | The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care | Operating standard of 80% | See Contract Technical Guidance Appendix 2 | Quarter | MH |
|  | Duty of candour | Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations | See CQC guidance on Regulation 20 at:  <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour> | Ongoing | All |
| E.H.4 | Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care | Operating standard of 60% | See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: <https://www.england.nhs.uk/mental-health/resources/access-waiting-time/> | Quarter | MH |
| E.H.1 | Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment | Operating standard of 75% | See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at:  <https://www.england.nhs.uk/operational-planning-and-contracting/> | Quarter | MH |
| E.H.2 | Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment | Operating standard of 95% | See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at:  <https://www.england.nhs.uk/operational-planning-and-contracting/> | Quarter | MH |

The Provider must report its performance against each applicable Operational Standard and National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A.

**SCHEDULE 4 – QUALITY REQUIREMENTS**

1. **Local Quality Requirements**

\*The CCG are currently undertaking a review of the previous quality dashboard and a revised quality monitoring report listing all the metrics below will be completed during April 2021 and will be uploaded to DPS for completion. All providers will be advised through the portal when full reporting will be in place. The metrics which are being identified will be reportable on monthly and quarterly submission as detailed within the portal.

| **Quality Requirement** | **Question sub category** | **Method of Measurement** | **Applicable Service Specification** |
| --- | --- | --- | --- |
| 1. What is the total occupancy over the reporting period (Record this as a number)? | Occupancy |  | All |
| 1. How many times did EMAS/EEAST attend for an unplanned/emergency call in the reporting period? | Hospital Admissions |  | All |
| 1. How many residents attended A&E or an Emergency Department and were admitted as an inpatient? | Hospital Admissions |  |  |
| 1. How many residents attended A&E and were not admitted in the reporting period? | Hospital Admissions |  | All |
| 1. How many residents were discharged from another setting without full patient information in the reporting period? | Hospital Admissions |  | All |
| 1. How many Quality Issues Report (QIR) forms did you log during the reporting period? | Hospital Admissions |  | All |
| 1. Have you undertaken a monthly care plan audit in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in medicines management in the reporting period? | Audit |  | All |
| 1. Have you undertaken an annual training needs analysis? | Audit |  | All |
| 1. Have you completed a monthly training review of staff competancies and mandatory training that is outstanding? | Audit |  | All |
| 1. Have you undertaken a monthly audit in falls in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in infection prevention and control, including health care acquired infections (HCAI's) in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly equipment audit (including medical devices) in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in nutritional screening and support in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in tissue viability in the reporting period? | Audit |  |  |
| 1. Have you undertaken a monthly audit in wound care practice in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in incidents/accidents for residents in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in incidents / accidents of staff in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in hospital admissions in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit of health and safety in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit for environmental infection control in the reporting period? | Audit |  | All |
| 1. Have you undertaken a monthly audit in response times to call bells in the reporting period? | Audit |  | All |
| 1. Have there been any outbreaks in the reporting period? | IPC |  |  |
| 1. Please provide further information related to these outbreaks (including type of outbreak and duration) | IPC |  | All |
| 1. Have these outbreaks been reported to Public Health England? | IPC |  | All |
| 1. In the reporting period, how many Urinary Tract Infections (UTI) were diagnosed? | IPC |  | All |
| 1. In the reporting period, how many residents were diagnosed as having UTI with a catheter? | IPC |  | All |
| 1. Of those UTI diagnosed, how many are a recurrence of an infection reported in the previous 3 months? | IPC |  | All |
| 1. State any changes made in relation to IPC in view of above? | IPC |  | All |
| 1. Have you had any residents admitted/returned with hospital acquired pressure ulcers? | Preventable Harms |  | All |
| 1. In the reporting period, how many new Care Home Acquired Pressure Ulcers Graded 1-2 have there been? | Preventable Harms |  | All |
| 1. In the reporting period, how many new Care Home Acquired Pressure Ulcers Graded 3-4 have there been? | Preventable Harms |  | All |
| 1. How many new Care Home Acquired Pressure Ulcers Ungradable care home pressure have there been? | Preventable Harms |  | All |
| 1. What changes to care delivery for these services users have you undertaken? | Preventable Harms |  | All |
| 1. In the reporting period, what were the total percentage of falls? | Preventable Harms |  | All |
| 1. In the reporting period, what were the number of falls resulting in moderate or above harm? | Preventable Harms |  | All |
| 1. Of those identified as having a falI in this reporting period, how many residents have had 2 or more falls in the previous 3 months? | Preventable Harms |  | All |
| 1. How many face to face/virtual ward rounds have been held during the reporting period? | Preventable Harms |  | All |
| 1. How many MDT meetings with more than one professional agency have been held in the reporting period? | Preventable Harms |  | All |
| 1. How many medication incidents (errors or near misses) have occurred during the reporting period? | Medicine Management |  | All |
| 1. How many of the above related to Controlled Drugs incidents have occurred in this reporting period? | Medicine Management |  | All |
| 1. Are you currently ordering medication through proxy ordering processes? | Medicine Management |  | All |
| 1. Number of residents on antipsychotics / sedatives for challenging behaviour / behavioural and psychological symptoms in Dementia (BPSD)? | Medicine Management |  | All |
| 1. In the reporting period how many times was the fridge temperature found to be outside of optimum range? | Medicine Management |  | All |
| 1. How many safeguarding referrals have been initiated by the home in the reporting period? | Safety |  | All |
| 1. How many safeguarding referrals have been initiated by external agencies in the reporting period? | Safety |  | All |
| 1. How many serious incidents have been reported in the reporting period? | Safety |  | All |
| 1. Have there been any low/no harm incidents in relation to behaviours that challenge in the reporting period. | Safety |  | All |
| 1. For each of the above incidents, how many resulted in | Safety |  | All |
| 1. How many residents have you assessed as having unexpected weight loss in the reporting period? | Nutrition & Hydration |  | All |
| 1. Has your Care Home had a change in manager since the last reporting period? | Management |  | All |
| 1. How many residents died in the reporting period? | End of Life Care |  | All |
| 1. How many of these deaths were unexpected (including hospital deaths)? | End of Life Care |  | All |
| 1. How many of the expected deaths were able to die in their preferred place of care? | End of Life Care |  | All |
| 1. Please state the number of hours required to deliver direct care during the reporting period (as established through your process for determining staffing levels). | Care Staffing |  | All |
| 1. Please state the number of hours required to deliver direct nursing care during the reporting period (as established through your process for determining staffing levels). | Care Staffing |  | All |
| 1. How many residents are receiving 1:1 care? | Care Staffing |  | All |
| 1. Of the residents receiving 1:1 care, is this care being delivered by | Care Staffing |  | All |
| 1. In the reporting period, overall how many hours were delivered by agency nurses? | Care Staffing |  | All |
| 1. Please provide details around your rationale for agency usage in the reporting period. | Care Staffing |  | All |
| 1. In the reporting period, how many care hours were delivered by agency carers? | Care Staffing |  | All |
| 1. Please state the number of hours that are delivered in an activity coordinator role. | Ancillary Staffing |  | All |
| 1. Please state the number of hours that are delivered in a Housekeeping/cleaning role. | Ancillary Staffing |  | All |
| 1. Please state the number of hours that are delivered in any other role. | Ancillary Staffing |  | All |
| 1. How many Care Staff do you employ? | Care Staffing |  | All |
| 1. How many care staff left during the reporting period? | Care Staffing |  | All |
| 1. How many vacancy hours in the reporting period did you have for Nurses? | Vacancies |  | All |
| 1. How many vacancy hours in the reporting period did you have for Carers? | Vacancies |  | All |
| 1. How many vacancy hours in the reporting period did you have for Catering? | Vacancies |  | All |
| 1. How many vacancy hours in the reporting period did you have for House keeping/Cleaning? | Vacancies |  | All |
| 1. How many vacancy hours in the reporting period did you have for Maintenance? | Vacancies |  | All |
| 1. How many vacancy hours in the reporting period did you have for Business support/administration? | Vacancies |  | All |
| 1. How many vacancy hours in the reporting period did you have for other? | Training |  | All |
| 1. In the reporting period, please provide the total % of staff that have completed mandatory training. | Training |  | All |
| 1. For any training areas which are under 75% compliant, please provide details of actions planned to address. | Training |  | All |

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. Reporting Requirements

\*All greyed out areas are not applicable

|  | **Reporting Period** | **Format of Report** | **Timing and Method for delivery of Report** |
| --- | --- | --- | --- |
| **National Requirements Reported Centrally** |  |  |  |
| 1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at <https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections>   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 |
| **National Requirements Reported Locally** |  |  |  |
| 1. Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)* | Monthly |  | On or before the 10th working day of the month following the month being reported to the email address below:  [CAPCCG.ceff@nhs.net](mailto:CAPCCG.ceff@nhs.net) |
| 1. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour | Monthly | Word/Excel | On or before the 10th working day of the month following the month being reported to [c](mailto:capccg.bi@nhs.net)apcgg.communitycontracts@nhs.net |
| 1. Capacity Tracker   All relevant areas to be updated daily. | Daily | CCG will review daily | Daily |
| 1. Summary report of all incidents requiring reporting | Monthly | Word/Excel | On or before the 10th working day of the month following the month being reported to [capccg.bi@nhs.net](mailto:capccg.bi@nhs.net) |

**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) Notifiable Safety Incidents (3) Other Patient Safety Incidents** |
| **Insert text locally** |

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

**F. Provider Data Processing Agreement**

|  |
| --- |
| **Where the Provider is to act as a Data Processor, insert text locally (mandatory template drafting available via** [**http://www.england.nhs.uk/nhs-standard-contract/**](http://www.england.nhs.uk/nhs-standard-contract/)**).**  **If the Provider is not to act as a Data Processor, state Not Applicable** |

# SCHEDULE 7 – PENSIONS

|  |
| --- |
| **Not Applicable** |

# SCHEDULE 8 – TUPE\*

1. The Provider must comply and must ensure that any Sub-Contractor will comply with their respective obligations under TUPE and COSOP in relation to any persons who transfer to the employment of the Provider or that Sub-Contractor by operation of TUPE and/or COSOP as a result of this Contract or any Sub-Contract, and that the Provider or the relevant Sub-Contractor (as appropriate) will ensure a smooth transfer of those persons to its employment. The Provider must indemnify and keep indemnified the Commissioners and any previous provider of services equivalent to the Services or any of them before the Service Commencement Date against any Losses in respect of:
   1. any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any relevant transfer under TUPE and/or COSOP;
   2. any claim by any person that any proposed or actual substantial change by the Provider and/or any Sub-Contractor to that person’s working conditions or any proposed measures on the part of the Provider and/or any Sub-Contractor are to that person’s detriment, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor; and/or
   3. any claim by any person in relation to any breach of contract arising from any proposed measures on the part of the Provider and/or any Sub-Contractor, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor.
2. If the Co-ordinating Commissioner notifies the Provider that any Commissioner intends to tender or retender any Services, the Provider must within 20 Operational Days following written request (unless otherwise agreed in writing) provide the Co-ordinating Commissioner with anonymised details (as set out in Regulation 11(2) of TUPE) of Staff engaged in the provision of the relevant Services who may be subject to TUPE. The Provider must indemnify and keep indemnified the relevant Commissioner and, at the Co-ordinating Commissioner’s request, any new provider who provides any services equivalent to the Services or any of them after expiry or termination of this Contract or termination of a Service, against any Losses in respect any inaccuracy in or omission from the information provided under this Schedule.
3. During the 3 months immediately preceding the expiry of this Contract or at any time following a notice of termination of this Contract or of any Service being given, the Provider must not and must procure that its Sub-Contractors do not, without the prior written consent of the Co-ordinating Commissioner (that consent not to be unreasonably withheld or delayed), in relation to any persons engaged in the provision of the Services or the relevant Service:
   1. terminate or give notice to terminate the employment of any person engaged in the provision of the Services or the relevant Service (other than for gross misconduct);
   2. increase or reduce the total number of people employed or engaged in the provision of the Services or the relevant Service by the Provider and any Sub-Contractor by more than 5% (except in the ordinary course of business);
   3. propose, make or promise to make any material change to the remuneration or other terms and conditions of employment of the individuals engaged in the provision of the Services or the relevant Service;
   4. replace or relocate any persons engaged in the provision of the Services or the relevant Service or reassign any of them to duties unconnected with the Services or the relevant Service; and/or
   5. assign or redeploy to the Services or the relevant Service any person who was not previously a member of Staff engaged in the provision of the Services or the relevant Service.
4. On termination or expiry of this Contract or of any Service for any reason, the Provider must indemnify and keep indemnified the relevant Commissioners and any new provider who provides any services equivalent to the Services or any of them after that expiry or termination against any Losses in respect of:
   1. the employment or termination of employment of any person employed or engaged in the delivery of the relevant Services by the Provider and/or any Sub-Contractor before the expiry or termination of this Contract or of any Service which arise from the acts or omissions of the Provider and/or any Sub-Contractor;
   2. claims brought by any other person employed or engaged by the Provider and/or any Sub-Contractor who is found to or is alleged to transfer to any Commissioner or new provider under TUPE and/or COSOP; and/or
   3. any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any transfer to any Commissioner or new provider.
5. In this Schedule:

**COSOP** means the Cabinet Office Statement of Practice *Staff Transfers in the Public Sector* January 2000

**TUPE** meansthe Transfer of Undertakings (Protection of Employment) Regulations 2006

**\****Note: it may in certain circumstances be appropriate to omit the text set out in paragraphs 1-5 above or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.*

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First published March 2021

Published in electronic format only

1. [↑](#endnote-ref-2)
2. [↑](#endnote-ref-3)
3. Transition to Care Home Nursing: <https://www.qni.org.uk/nursing-in-the-community/transition-community-nursing/care-home-nursing/> [↑](#footnote-ref-2)
4. NPUAP Pressure Injury Stages: <https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/> [↑](#footnote-ref-3)
5. CQC Standards: [www.cqc.org.uk/content/fundamental-standards](http://www.cqc.org.uk/content/fundamental-standards) [↑](#footnote-ref-4)
6. Adapted from: CQC, 2017. What can you expect from a good home-care agency? Available at: <https://www.cqc.org.uk/help-advice/what-expect-good-care-services/what-can-you-expect-good-home-care-agency> [↑](#footnote-ref-5)
7. NHS Outcomes Framework 2016 to 2017. Available at: <https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017> [↑](#footnote-ref-6)
8. The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions- Available at: <https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions> [↑](#footnote-ref-7)
9. Department of Health, 2018. *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*. <https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care> [↑](#footnote-ref-8)