SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Provision of Nursing Care Home Services for people with complex physical health needs.**
Commissioner Lead	**Toni Smith. Head of Continuing Care** **V 2.0 Viv Nicholson. Senior Clinical Commissioning Manager**
Provider Lead	
Period	**1 April 2020 – 31 March 2021**
Date of Review	**November 2020**

1. Population Needs

1.1 National/local context and evidence base

1.1.1 The Joint Health and Wellbeing Strategy Vision (2014-2020) was developed by Kirklees Local Authority and NHS North Kirklees Clinical Commissioning Group (NKCCG) and NHS Greater Huddersfield CCG (GHCCG), the Strategy states that "by 2020, no matter where they live, people in Kirklees live their lives confidently, in better health for longer and experience less inequality".

1.1.2 Across Kirklees as a whole, two in three adults (68%) have a Long Term Condition (LTC), more than half of these (54%) have more than one condition and one in eleven have four or more. Living with more than one LTC increases the impact on personal functioning and the level of support needed.

1.1.3 The current population of Kirklees is approximately 440,000: of that total population it is estimated that 3%-4% live in a care home.

1.1.4 The National Framework (NSF) for NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC), revised October 2018, (www.dh.gov.uk/publications), sets out the principles and processes and defines the national requirements and statutory duties for CCGs and Local Authorities in relation to the eligibility for NHS continuing healthcare.

1.1.5 Continuing Care involves a package of care that is arranged and wholly funded by the NHS. The criteria for eligibility for CHC are set out in the NSF for NHS Continuing Health Care. The eligibility for NHS CHC places no limits on the settings in which the package of support can be offered or on the type of service delivery.

1.1.6 NHS FNC is the funding provided by the NHS to care homes to ensure the provision of nursing care by a registered nurse. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached.

1.1.7 Those Service Users identified as eligible for NHS CHC or a contribution from the CCG will have been identified by the CCG as requiring one of the above services. The Care Homes covered by this specification are those registered with the CQC to provide nursing care to service users with a physical disability. The Provider will deliver services from a fixed bed base, which offers the flexibility and expertise to meet the needs of those Service Users who require complex care interventions, treatment and support as a consequence of their complex physical health needs.

1.1.8 It is expected that the service will be able to provide high-level complex care to those individuals requiring the following.

- long term care
- 'step up' support to prevent admission to hospital
- short term symptom management support
- respite

2.0 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**	✓

2.2 Local defined outcomes

2.2.1 The key service outcomes below are based on the NHS Outcomes Framework[1] and Adult Social Care Outcomes Framework[2]

[1]NHS Outcomes Framework 2019 to 2020 – Available at:
https://www.gov.uk/government/publications/nhs-outcomes-framework-2019-to-2019

[2]The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions – Available at:
https://www/gov.uk/goverment/publications/adult-social-care-outcomes-framework-handbook-of-definitions

- 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
- 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.

2.2.2 The Provider will provide Services to Service Users in accordance the NHS Standard Contract, this Service Specification and with their personalised care plan.

2.3 Principles of Care

2.3.1 Provision and delivery of care will be through an in house multi-disciplinary team based approach, inclusive of RGN/ RMN, Physiotherapists and Occupational Therapists.

2.3.2 The Provider will ensure that it has a clearly identified pathway for referral to other professionals that maybe required providing input to the provision and delivery of care e.g. Speech and Language Therapists, Dieticians, Psychologists, specialist Mental Health Services.

2.3.3 The following principles of good practice should be incorporated into day to day policy:

- Service Users have the same human value and rights as anyone else and will be treated with the same dignity and respect as any other citizen.
- Care will be based on an individual person-centred assessment taking a holistic account of their broader circumstances and needs.
- Care will be provided in a way that maximises independence and inclusion.
- Service Users will participate in decisions affecting their daily lives as far as possible. The views of families and carers should be sought.
- Service Users who are unable to participate in decision making will have access to an advocate.
- Carers will be appropriately involved in planning the care of their relative and will have their needs assessed and taken into account.

Service Users and Carers will be given speedy and accurate information to support decision making.

3. Scope

3.0 Aims and Objectives of the Service

3.1.1 Continuing Health Care means a package of ongoing care that is arranged and funded solely by the NHS to meet health and associated social care needs that have arisen as a result of disability, accident or illness. Individuals may be considered as needing the Service for a short period, although on many occasions Service Users will require long-term assistance.

3.1.2 The Continuing Health Care criteria requires Service Users to have regular eligibility reviews and re-assessment of their needs to ensure that the Services provided are the most appropriate to meet the Service User's long term needs(NSF 2018). Where the level of need is identified to have increased or decreased it is expected that the interventions/support to meet needs will alter accordingly to reflect any change. The review will be led by the NHS and involve the Service User (where possible), Carers and /or an advocate.

3.1.3 The service will be flexible to meet the complex needs of individual Service Users in order to reduce the requirement for out of area placements. It is expected that the Provider will support the repatriation of patients to the local area where the individual chooses to do so.

3.1.4 The Provider will support the overall strategic aims of the CCG to ensure that the population of NHS NKCCG and NHS GHCCG has the best possible health care outcomes by commissioning high quality, equitable and integrated services.

3.1.5 To provide a high quality, skilled service to adults over the age of 18 year with complex physical health needs who require 24 hour care.

3.1.6 To ensure that the Provider has a consistent level of appropriately skilled and competent qualified health professionals and care workers, commensurate with the requirements of the specification to meet the physical, mental, emotional, cognitive and cultural care needs of the Service User. It is assumed that Registered General Nurses (RGN) are the most appropriately qualified nurses for this client group

3.1.7 To improve the organisation and co-ordination of care provision to benefit discharge processes and community care that potentially will have an impact on avoiding hospital admissions and reduce length of stay where an acute admission is required.

3.1.8 The Provider will deliver high quality care home services for people with complex physical disability needs. Service Users will have a regularly reviewed Personalised Care Plan which is person centred and which will ensure that they access meaningful and fulfilling activities. The Provider agrees to be involved in cross professional working both with the local authority and the NHS

3.1.9 The Provider will ensure that Service Users are supported to access appropriate healthcare through mainstream primary and secondary care

services to meet their identified health needs (treatment and prevention).

3.1.10 For the avoidance of doubt the Provider will not be required to accept any placement during the term of this Agreement, nor will the Commissioner guarantee to make any placements during the term of this Agreement. The Commissioner will only pay for Services delivered in accordance with the personalised care plan.

3.2 Service description/care pathway

3.2.1 The Provider shall be appropriately registered with the Care Quality Commission (CQC) and comply with the associated national standards and the standards specified in this Agreement.

3.2.2 The provider will ensure that the services can be provided 365/6 days a year, 24 hours a day and in accordance with the Service Users personalised care plan. Prior to each placement a detailed assessment will be carried out by the Provider to ensure that the needs of the Service User and existing Service Users can be met. If the Service User has nursing needs the assessment must be carried out by a qualified nurse, ideally the clinical lead.

3.2.3 The Provider must ensure that Service Users and Carers have clarity about what the care home provides prior to admission to the care home. If a Service User has been awarded Continuing Health Care, the funding will cover every aspect of the Service User's care provision in line with the assessed need.

3.2.4 The Service User will also have full access to all NHS Services and must register with a local General Practitioner. There should be no extra charge for NHS Services if an individual is identified as having a clinical requirement for that Service. This includes primary care Services such as podiatry and physiotherapy.

Service provisions will include the following:

- The Provider will establish and record how care and support will be specifically delivered in accordance with the Service User's and that of their family/carers, needs and wishes.
- The Provider will ensure that all care team members are given an appropriate and adequate briefing regarding the Service User's needs and specific details of the way in which they are to be met.
- Care team members must provide the service specified in the Personalised Care Plan.
- The Provider must respect confidential information gained in the course of professional practice and ensure that no such information is passed on to anyone who does not have a right to that information.
- The Provider must ensure that Services are delivered promptly, taking into account the dignity of the Service User at all times.
- The Provider must ensure that it has an appropriate governance structure in place at all levels of the organisation to ensure the delivery of high quality care and early detection of any issues or risks.
- The Provider has a responsibility to alert the Commissioner if there are any concerns identified that may have an impact on the standards of care delivered.

- The Provider will notify the Commissioner immediately when a Service User is admitted to hospital and will keep the
- Commissioner updated as to the progress of the Service User. After a period of 28 days the Provider will make a request to the Commissioner in relation to the continuation of the individual placement. The Commissioner will advise the Provider whether or not the placement should continue, or provide notice that the placement is terminated with immediate effect. The Provider acknowledges that the Commissioner will make no further payment in respect of a placement that has terminated.
- It is the responsibility of the provider to inform the commissioner of the death of a service user within 24 hours. In the event that a Service User dies, the Commissioner will pay for Services for up to 3 days after the date of the Service User's death.
- The Provider is required to give 28 days' notice to the Commissioner of their intention to suspend or terminate an individual Care Package in order to allow sufficient time for the Commissioner to commission a suitable replacement Care Package. In exceptional circumstances the Provider may be asked to continue providing care until such time as that replacement can be secured.

3.3 Population covered

3.3.1 Individuals who are registered with either a North Kirklees GP or Greater Huddersfield GP (subject to "Who Pays?" Guidance) over the age of 18 years.

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 The Provider will accept referrals from the Continuing Care team following a robust decision making process. It is the role and responsibility of the Commissioner's CHC Team to provide the referral detail and to transfer any other information held. This will include any pertinent information to enable the Provider to deliver a more tailored care package to meet the Service User's need.

3.4.2 Service Users who do not meet the Continuing Health care criteria for CHC or FNC should be referred to appropriate Services. Any Service User who no longer meets the eligibility criteria following review will receive 28 days' notice of the intention to cease health funding. All initial referrals will be from the CHC team hosted by North Kirklees CCG on behalf of both North Kirklees and Greater Huddersfield CCGs.

3.5 Interdependence with other services/providers

3.5.1 The Services will be delivered in partnership with the Commissioner, Kirklees Local Authority and other health and social care Providers required by the Service User.

3.5.2 The Provider is expected to refer the Service User to any other service where a commissioned service can enhance their care.

3.5.3 The provider is expected to participate in all local service and pathway developments related to their area of service delivery.

3.6 Service Model Care Environment, Amenities and Activities

3.6.1 Services will be provided in a smoke free environment in line with the Health Act 2006. There will be wheelchair/disabled access for Service Users and visitors. There should be sufficient space to accommodate Service Users/visitors walking aids.

3.6.2 The Provider shall ensure that care is provided in an environment that promotes patient and staff safety and well-being, as well as respect for the Service User's needs and preferences. The environment shall be designed for the effective and safe delivery of care ensuring at all times that the privacy and dignity of Service Users is maintained

3.6.3 Décor and furniture will be pleasant both in the care home communal areas and the Service User's room. Service Users should be involved in decisions about décor and furnishings, where possible.

3.6.4 All reasonable steps must be taken to ensure the safety and security of the Service User and their personal belongings. An inventory should be taken at the commencement of the placement and agreed with the Service User and the Carer.

3.6.5 The laundry facilities must be organised to ensure that the Service User's clothes are not misplaced. Where clothes are lost or damaged by the laundry service the Service User must be reimbursed for the loss.

3.6.6 The Provider must maintain an email system to ensure that all transfers of patient identifiable data is secure. GDPR principles must be observed at all times (see section 3.8.5). A secure e mail address must be in place.

3.6.7 The Provider must have safe and effective procedures for medicines management which comply with CQC and CCG Guidelines.

3.6.8 Appropriate cleaning regimes will be in place to ensure that continence issues do not cause concern and the risk of infection is minimised.

3.6.9 Appropriate equipment must be available on site.

3.7 Care Plans

The essential component in meeting the needs of the Service User is the Personalised Care Plan developed by the Provider.

- The Provider will have systems and policies in place to ensure that it is responsive to the individual needs of its service users and will demonstrate it makes all reasonable adjustments to ensure that its services are accessible, appropriate and flexible.
- The Provider will consider the specific needs of protected groups in relation to the service provided, making specific arrangements where necessary, such as interpreters.
- All protected characteristics will be considered and adjustments made, but particular attention will be to people who may have

additional communication requirements. Providers will comply with the NHS Accessible Information Standard.

- The provider will produce accessible materials and signposting information to publicise and promote the service as required. The information will include a clear description of how the service operates, how it fits with other services, what to expect from the service (in terms of processes and outcomes) and how to register a compliment/complaint.
- The Provider will ensure that information about the service is provided to all individuals using the service and potential service users and their carers/family, in appropriately accessible formats.

This information should reflect the diversity of the local community

- The Provider shall ensure that care is provided in partnership with Service
  Users and Carers, respecting their diverse needs, preferences and choices
  and in partnership with others, (especially the NHS) whose Services impact
  on well-being.

3.7.1 The Provider will ensure that the client has an individual Personalised Care Plan which will detail how the Service User needs will be met. All individualised plans should include but not be limited to the following:

- Risk Management
- Nutrition
- Falls prevention
- Manual handling
- Medication (Symptom Control/ Management)
- Continence
- Breathing
- Altered States of Consciousness
- Tissue viability
- Spiritual/cultural
- Behavioural management, where applicable
- Safeguarding
- Palliative care including Advanced Care Planning
- Equipment needs

3.7.2 Prior to admission it is expected that the Provider will carry out a thorough pre-admission assessment which identifies individual needs and risks in order to ensure safe Personalised Care Planning on admission.

3.7.3	On admission to the care home as part of the initial assessment and development of the Personalised Care Plan, a body map should be completed, recording any marks, tears to the skin or any pressure sores. The body map should be reviewed regularly during Personalised Care Plan reviews and in the event of any incidents and kept updated. Any findings must be recorded in the Service User's Personalised Care Plan with relevant supporting information .
3.7.4	Please note: Where a resident is admitted to hospital for an in-patient stay it is expected that the Provider re-assesses their needs prior to their return to the care home.
3.7.5	The Personalised Care Plan sets out in detail the action that will be taken by the Provider to meet the assessed needs, including specialist needs and communication requirements and identifies areas of flexibility to enable the Service User, where appropriate to maximise their potential and maintain independence in the care home.
3.7.6	The Personalised Care Plan is drawn up with the cooperation of the Service User, and if appropriate, their relatives or any other professionals and agencies that may be involved in their care. Changes to the Personalised Care Plan shall be recorded accordingly and shared with the CHC Team. The Personalised Care Plan will clearly outline any necessary escalation processes and the limitation of the Provider's role, including contact details of more senior clinical decision makers in response to deterioration or change in need.
3.7.7	Personalised Care Plans should be developed with Service Users and Carers to reflect the Service User's physical, social and emotional needs. The Personalised Care Plans should provide evidence that it is regularly reviewed with the Service User and Carer and adapted to reflect any change in the Service's needs.
3.7.8	Personalised Care Plans should reflect the needs and wishes of the individual, facilitating choice and delivering a Service that respects the privacy and dignity of the Service User at all times.
3.7.9	Personalised Care Plans should be updated and reflect the current health needs of the individual with clearly defined actions to meet these needs. It is expected that the Personalised Care Plan format will clearly identify the process of assessment, planning, implementing and evaluating care. This record should enable any nurse/carer to identify a Service User's needs and provide the appropriate care required. Individual daily logs must be available for the CHC team at the time of review.
3.7.10	Personalised Care Plans should identify any nursing needs and actions with clear timescales for tasks, e.g. blood pressure monitoring, re-positioning chart, fluid balance chart, wound chart, etc.
3.7.11	It is recommended that the Named Nurse takes responsibility for Personalised Care Planning for their allocated Service Users to ensure that all Personalised Care Plans are completed to reflect best practice.

3.7.12 The Registered Manager/Clinical Lead should take responsibility for ensuring the standard of Personalised Care Plans and coordination of overall care provision.

3.7.13 The Provider shall ensure that adequate time is allowed and a clear handover system is in place at the change of shifts for nursing staff or care staff to communicate relevant information regarding the care of Service Users.

3.7.14 The Provider shall ensure that in the event of a Service User being transferred to another care setting they are accompanied by a copy of the up to date body map and all relevant documentation. to assist the Provider in establishing the right level of care required by the Service User

3.7.15 Risk Assessments and management plans must be reviewed on a regular basis and whenever the Service User's circumstances change, such as following a period of hospitalisation or change in medication regime. All professionals involved in the provision of care to the Service User may be involved in that review as circumstances dictate.

3.7.16 A comprehensive plan to manage or mitigate any risks identified should be in place. A copy of all Risk Assessment shall be retained by the Provider in the Service Users Personalised Care Plan.

3.7.17 Risk planning should take in to account the process for Staff to take should they identify a new risk. This may also require the Provider to escalate the risk to the Commissioner.

3.7.1 The risk assessment may also include the actions the Providers should take if the Service User or their representatives become aggressive, abusive or cause harm or self-harm, in order to minimise the risk to the Provider and to the Service User.
All nurses must maintain a high standard of record keeping in line with Nursing and Midwifery Council (NMC) Code.

3.8 Management of the Home and Services

3.8.1 The Provider shall demonstrate that their managerial leadership, clinical leadership and accountability, as well as the culture of the organisation, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the organisation.

3.8.2 Staff competency must be maintained through regular training and development. All management and staff involved in providing the Services will be required to undertake regular training in care provision for older people and to update their knowledge and skills in line with good practice

3.8.3 Staffing levels will be dependent upon the needs of the Service Users as identified in the Personalised Care Plan.

3.8.4 The Provider's Business Continuity Plan must be updated on an annual basis and be made available to the Commissioner.

3.8.5 As part of the implementation of the requirements of this specification, the

Provider shall ensure due consideration has been given to the requirement under the General Data Protection Regulation/Data Protection Act 2018 to undertake a Data Protection Impact Assessment (DPIA) where the processing of personal identifiable data is likely to result in a high risk to the rights and freedoms of individuals.

3.9.1 The Provider shall ensure that care is provided in partnership with Service Users and Carers, respecting their diverse needs, preferences and choices and in partnership with others, (especially the NHS) whose Services impact on well-being.

3.9.2 Where an advocate is requested or required the provider should facilitate a referral on behalf of the Service User.

3.9.3 The Service Provider must:

- ensure visiting therapists, clinicians and other specialist health and social care staff are provided with adequate facilities and support to undertake their work.
- allow access to service users and their records to support assessments and reviews .The commissioner accepts that where possible scheduled reviews should avoid protected times, for example prior to 9.30 am and meal times.
- ensure that a member of staff who cares for the service user regularly is available for the duration of the review.
- ensure that individual Service Users progress is reviewed on a daily basis and recorded in Personalised Care Plan. The reviews and the care provided to be carried out in a way that is person centred, i.e. reflects the needs and personality/experience of each individual Service User.
- make suitable and immediate arrangements when a Service User requires emergency treatment or admission to hospital.
- work with the Commissioner to enhance care packages should this be required following assessment and in order to prevent the breakdown of care provision.
- ensure that Service Users and Carers are fully consulted about the care being provided or planned and provided with comprehensive information in an appropriate format taking into account the mental Capacity Act 2005 and any relevant legislation or guidance.
- consider the specific needs of protected groups in relation to the service provided, making special arrangements where necessary.
- have systems/procedures/policies in place to provide equality monitoring information and report this to the commissioner as required. The provider will evidence any actions taken to address any preventable inequalities of experience or outcomes where these become apparent. They must ensure that where, where appropriate, they provide services equitably to all service users.
- take in to account the Service User's religious and cultural needs at all times.
- The Provider will comply with the NHS Accessible Information Standard.

3.10 Personal Care

3.10.1 Guidance on good practice is contained in the CQC Fundamental Standards. The Provider will comply with safeguarding procedures.

3.10.2 The Provider will comply with safeguarding procedures.

3.10.3 The Services will be delivered in a way that demonstrates respect for the privacy, dignity and value of all Service Users irrespective of severity of disability or personal circumstances.

3.10.4 The Provider must ensure that the Service User is supported to maintain good oral health, including regular dental checks and support to clean teeth.

3.11 Staffing

3.11.1 Recruitment of staff must be undertaken in accordance with the requirements of the CQC and this Agreement.

3.11.2 The Provider will be expected to demonstrate how they are able to provide and maintain holistic care provision through their recruitment processes.

3.11.3 All nurses must have current and up to date registration with the NMC (RGN).

3.11.4 Nurses must at all times act in a competent manner that adheres to the professional codes of conduct as determined by the NMC.

3.11.5 All nurses are required to maintain their registration through meeting the post-resignation revalidation standards set by the NMC.

3.11.6 The Provider shall assign to the Services sufficient qualified and trained staff to provide and supervise the Services at all times. The staff shall have the skills, competence and expertise necessary to deliver the Services. Sufficient reserves will be available to provide cover for holidays, sickness and absence. The use of Agency staff should be minimised to ensure continuity of care.

3.11.7 The Provider will seek the relevant medical/specialist advice for the Service User where and when it is appropriate as determined by their health needs.

3.11.8 The Provider will determine the number and skill mix of staff required on a day to day basis taking into account the number of Service Users living in the home, individual Service User requirements, the level and type of need and the layout of the home.

3.11.9 The provider will have an identified Lead Nurse who will be responsible for ensuring the delivery of high quality, safe and effective care, ensuring the maintenance of professional standards and the supervision of qualified staff.

3.11.10 Where there are Service Users with an identified nursing care need, the Lead Nurse will be accountable for ensuring the assessment, planning, implementation and evaluation of the care.

3.11.11 The Provider shall ensure that all nurses participate in the supervision and mentoring of care staff and delegation of appropriate workload in order to

deliver an exemplary level of care.

3.11.12 The Provider will support staff in accordance with CQC requirements but will also take into account that extra support may be required for both staff and management depending on the needs of the Service Users.

3.11.13 Evidence of effective case management will be required given the complex nature of this service user group, with escalation procedures and risk assessments in place which are fully understood by every member of staff involved in care provision.

3.11.14 Staff will receive regular supervision and annual appraisal in accordance with CQC guidance and good practice.

3.12 Discharge Criteria and Planning

3.12.1 The Provider will work with the Commissioner to ensure that where people are moving out of the care home their needs are met in the interim period and to ensure that the transition is smooth, for example admission to hospital or change to long term placement. This may involve working with other Providers who may be taking over service provision.

3.13 Service Review and Information Requirements

3.13.1 If there is a significant change in needs of a Service User the Commissioner must be informed immediately. Any changes to staff ratios must be agreed in writing by the Commissioner. The Provider must ensure however, that the needs of the Service Users are met at all times in accordance with CQC Requirements and this Agreement.

3.13.2 The Commissioner must be informed orally immediately of any incidents affecting a Service User. Confirmation in writing must also be sent with immediate effect to NKCCG.ContinuingHealthcare@nhs.net. The Provider must follow the NHS Yorkshire and Humber procedure for management of serious incidents.

3.13.3 The Provider will cooperate at all times with the Commissioner's reviewing process, ensuring that information is accessible. Monitoring visits may be announced or unannounced and the Provider will be expected to provide information relating to all aspects of the Services being provided.

3.13.4 The Provider will have systems/procedures/policies in place to equality monitor referrals and service users, and will report this as required to the commissioner. The provider will evidence actions undertaken to address any preventable inequalities of access, experience or outcomes, where these become apparent. They must ensure that they are, where appropriate, providing services to the local community equitably.

3.13.5 The Provider will assess the impact of its services and work with service users and other stakeholders to understand whether there are any barriers to improved access, experience or outcomes. Where these are identified, reasonable steps should be taken to minimise the impact of the barriers.

3.13.6 The Provider must carry out an annual audit of its compliance with these obligations and must demonstrate at Review Meetings the extent to which service improvements have been made as a result of the audit outcomes.

4.0 Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

4.1.1 Services will be provided in accordance with CQC regulations.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.2.1 Nursing care will be provided in accordance with the NMC Code of Conduct and in line with the core values of nursing . The Standards required by allied health professionals will be determined by the individual professional bodies.

4.3 Applicable local standards

4.3.1 Medicines Management

The Provider will have clear policies and procedures relating to all aspects of medicines management and medicines handling when delivering a package of care, in line with the NHS North Kirklees and NHS Greater Huddersfield CCG's Medicines Code.

Where appropriate, individuals should be encouraged and supported to take control of their own medication.

4.4 Infection Control

4.4.1 Infection prevention and control including healthcare associated infection is everyone's responsibility and requires cooperation and information sharing across healthcare organisations in order to effectively manage, monitor and reduce the incidence of infection.

4.4.2 NHS North Kirklees and NHS Greater Huddersfield CCG's work in partnership with other agencies across Kirklees and the wider health economy to prevent and control infection. There is an expectation that Providers who are commissioned have systems and processes in place which meet the requirements of the Health and Social Care Act 2008: Code of Practice for the prevention and control of infections and associated guidance (DH 2010).

4.4.3 Providers are expected to be able to demonstrate proportionate compliance with the following:

- Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible Service users are and any risks that their environment and other users may pose to them.
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Provide suitable accurate information on infections to Service users and their visitors.

- Provide immediately suitable accurate information on infections to
- any person concerned with providing further support or nursing/medical care.
- Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
- Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

- Provide or secure adequate isolation facilities.
- Secure adequate access to laboratory support as appropriate.
- Have and adhere to policies that will help to prevent and control infections.
- Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

4.5 Reporting Requirements for Infection Prevention and Control

4.5.1 Provide information that indicates compliance with the Health & Social Care Act 2008, Code of Practice for the NHS on the prevention and control of healthcare associated infections (see HCAI assurance framework) (annual – plus updates on amber and red factors in monthly report).

4.5.2 Provide uptake data on staff immunisation against influenza (no of eligible staff/no of eligible staff vaccinated) cumulatively on a monthly basis from October to February. It is the responsibility of the employer to make available and fund influenza vaccination of all their care staff annually. **(Monthly report from October-February).**

4.5.3 Complete a full infection prevention and control audit of the care home annually using the approved tool. Report and action plan to be submitted to the Infection Prevention and Control team on completion of the audit. **(confirm annually – plus actions to be taken included in the next quarterly report).**

4.5.4 Complete audits of key IPC policies i.e. Hand hygiene, PPE, workwear policy and sharps management using the approved tools – one per month **(summarise audit results and actions arising in quarterly report).**

4.5.5 Report outbreaks/incidents relating to infection prevention and control to the infection prevention and control team of Kirklees and all outbreaks to Public Health England as they occur and cooperate fully with IPC and PHE advised control measures and investigations **(summarise newly reported issues in quarterly report).**

4.6 Provider Compliance with Safeguarding Standards

The CCG have in place comprehensive safeguarding standards for services who deliver care and treatment to children and adults, of which child and adult protection/safeguarding is a key component in all contracts with provider organisations. The provider is expected to adhere to standards that

are relevant to their service, particularly:

- Have in place an identified safeguarding Lead for safeguarding children and adults and a Prevent Lead for staff to seek support and advice from
- All staff must undertake safeguarding adults and children training appropriate to their role and grade, This includes all staff must have at least an awareness of the Government Prevent Strategy among that is in line with the NHS England Prevent Training and Competencies Framework.

- Be able to demonstrate staff compliance with agreed multi-agency Safeguarding procedures for adults and children (Safeguarding Adults the West Yorkshire, North Yorkshire and York Multi-agency Policy and
- Procedures & West Yorkshire Consortium Procedures Safeguarding Children), the Mental Capacity Act & Child Sexual exploitation processes
- Adherence to safe recruitment policies and practices which meet Employment check standards including ensuring that appropriate CRB/DBS checks are completed and repeated with national requirements and guidance.
- Ensure that all contracts of employment (Including volunteers, agency staff and contractors) include an explicit responsibility for safeguarding children and adults
- Ensure that there is a system for monitoring complaints, incidents and service user feedback, in order to identify and share any concerns of abuse (including potential neglect), using multiagency safeguarding procedures.

5.0 Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.1.1 Not Applicable

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

5.2.1 Not applicable

6.0 Location of Provider Premises

6.1 The Provider's Premises are located at:

- INSERT NAME

Appendix A

Individual Service Agreement Template

INDIVIDUAL SERVICE AGREEMENT

PURCHASER:	
PROVIDER & CONTACT NUMBER:	
SERVICE USER:	
CONTACT:	
TELEPHONE NO:	
AGREED SERVICE PROVISION:	
AGREED WEEKLY RATE:	
AGREED BANK HOLIDAY:	
COMMENCEMENT DATE:	
ELIGIBILITY:	
PURCHASE REFERENCE NUMBER:	

ISSIONER ACCEPTANCE

TURE……

ION ……..

……..

PROVIDER ACCEPTANCE

SIGNATURE……

POSITION ……..

DATE……