

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	11J/224
<b>Service</b>	Off Framework Domiciliary Care - Adults
<b>Commissioner Lead</b>	Personal Health Commissioning Dorset Clinical Commissioning Group
<b>Provider Lead</b>	
<b>Period</b>	1 <sup>st</sup> April 2019 – 31 March 2022
<b>Date of Review</b>	1 <sup>st</sup> September annually

#### 1. Population Needs

Dorset has a registered population of 809,726, of whom 658,627 are 18 or older and may access this service. This Service Specification covers commissioning of Domiciliary (Home) Care services by NHS Dorset Clinical Commissioning Group (Dorset CCG) for NHS Continuing Healthcare (CHC) where it has not been possible to engage a Provider who is a party to Dorset CCG's Framework Agreements with the relevant Local Authority. The service user is visited at various times of the day or, in some cases, care is provided over a full 24-hour period. The needs of those using the service may vary greatly and packages of care are designed to meet individual circumstances. Where there is good quality care, provided throughout the day, the Service User may live independently of any continuous support or care between the visits.

#### 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	✓

##### 2.2 Local defined outcomes

- Service Users receive the care and support they need and have an enhanced quality of life;
- Service Users and their families/representatives have a positive experience of care and support;
- Service Users are helped to recover from episodes of ill health or following injury;
- Service Users are cared for in a safe environment and protected from avoidable harm;
- Service Users are treated to minimise pain, discomfort and anxiety, whilst maximising quality of life;
- Health-related quality of life for Service Users with long-term conditions;
- Enhancing quality of life for Service Users with mental illness;
- Time spent in hospital by Service Users is minimised;
- Service Users feel supported to manage their condition;
- Service Users have optimised control over their daily life;

- The Provider works co-operatively with the relevant services to meet desired outcomes.

### 3. Scope

#### 3.1 Aims and objectives of service

The service will be provided for Service Users who have been determined by the Commissioner as having an NHS-funded Continuing Healthcare (CHC) entitlement.

The Provider will ensure that the services can be provided every day of the year, 24 hours a day and in accordance with a Service User's Agreed Health Outcome Plan<sup>1</sup>.

The aim is to provide care that is of a high quality and is person-centred, working with Staff 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, Staff 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 the delivery of a Personalised Care Plan that is safe and promotes a good quality of life, meets assessed needs and contributes to the outcomes identified for each individual Service User, and to contribute to the reduction of inappropriate hospital admissions where service users have expressed a wish to be cared for within their own home.

The aim of the service is to deliver domiciliary (home) 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 Continuing Health Care;
- meets the outcomes outlined in section 2 of this service specification through effective working partnerships;
- strives to continuously improve the quality of care for the Service User;
- provides continuity of care for the Service User, wherever possible;
- provides an explanation and apology from Providers when services are not delivered to plan;
- is delivered by the required number of Staff who 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;
- Staff have the required skills to meet their needs, including for Service Users receiving End of Life care;
- the care provided is carried out in a way that shows an understanding of and a concern for the Service Users and their support network,

#### 3.2 Service description/care pathway

The Service User will have had their eligibility assessed for NHS Continuing Healthcare and agreed in accordance with prevailing policy and guidance. The Service User may also be in receipt of other services from the Local Authority and / or hospice provision. End of Life Care (EoLC)<sup>2</sup> is not a separate Service but where required is part of the care given for all Service Users

<sup>1</sup> Agreed Health Outcome Plan – a document setting out the Health needs of the Service User which the Provider, the content of which is agreed between the Commissioner and the Service User or their representative.

<sup>2</sup> End of Life care is support for people who are in the last months or years of their life.

### 3.3 Population Covered

Any Adult Service User registered with a Dorset GP.

### 3.4 Any acceptance and exclusion criteria.

All Service Users must have been assessed as eligible for NHS Continuing Health Care

### 3.5 Interdependence with other services/providers

This Service is part of the wider health and social care provision. The Provider and Commissioner will work in partnership with GPs, primary healthcare teams, acute providers, Local Authorities, secondary care, the voluntary and community sector, and independent providers (this is not an exhaustive list)

## 4. Applicable Service Standards

### **Eligibility**

The Commissioner will assess the appropriateness of the Service User's package, at 3 months and at least annually thereafter. Where there is clear evidence of a change in need, to the extent where it may impact on the Service User's eligibility, the CCG will arrange a full reassessment via an MDT (Multi-Disciplinary Team)

The provider must:

- Inform the Commissioner of any changes in care need (increase or decrease) that may indicate a review of care package is required via the e mail address stated in Schedule 2 Part G
- provide appropriate representation to participate in the MDT process; this may not require full attendance of the MDT meeting
- provide access to or copies of all care assessment information and documentation, at the request of the Commissioner, to facilitate review of care needs and care package.

If, as a result of the reassessment, the Service User no longer meets the eligibility criteria for CHC the Commissioner will formally notify the Service User and Provider.

### **Service User Needs**

The Commissioner will be responsible for (in consultation with the MDT) identifying the Service Users care needs and will produce an Agreed Health Outcome Plan (AHOP) detailing the needs of the Service User and how the Provider, will meet those needs.

The Provider will develop their own Care Plan<sup>3</sup> to meet the needs in consultation with the MDT, and the Service User. Its contents will be reviewed on an ongoing basis and the Provider will maintain a record of those reviews. The Provider will also ensure that the Care Plan and any reviews are known to all relevant parties, including all those involved in the care of the Service User.

The provider is required to aid personalized care. Personalized care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. Creating a culture of personalisation and supported self-management benefits everyone and the principles are applicable to anyone using health services. Supporting people by increasing their knowledge, skills and confidence to self-manage has benefits for everyone:

- ✓ better health outcomes

<sup>3</sup> Care Plan – a plan produced by the Provider setting out how the service to be delivered will address the needs identified in the AHOP

- ✓ improved experience for service users
- ✓ services and resources are used more effectively

The key aspects of the personalised care model are:

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets.

Every provider is expected to embed this approach across their service delivery and demonstrate how we capture the personalised care and support planning that is being delivered, the tools used and the outcomes achieved.

Further information can be found at:

<https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/>

### **Care Plans**

The Care Plan must contain the following sections:

*Contact Details* – Details of the Service User, other family members, Carers, MDT professionals and Dorset CCG's contact details, including the named case coordinator for the Service User. Any correspondence with the Commissioner will be via specified Delivery Methods

*Medical History* – this must include (but is not limited to) the Service Users diagnosis and relevant medical history, including any allergies. It will record the Service Users medication and how it is administered and by whom, and whether any specific training is required. It will include clear instructions on medication management and be informed by discharge documents, mobilisation plans, Transition Arrangements, and the existing medicine administration records (MAR).

*Person Centered Information* – this must record the Service User's needs and the corresponding Provider requirements to meet those needs. It should state the Service Users preferences as informed by the "Service User passport", including a description of the outcomes for the care package.

*Carer Information* – The Care Plan will include the roles and needs of any Carers associated with the care package.

*Risk Assessments* – The Care Plan must include risk assessments with regard to the provision of care for the Service User, Carers and other persons associated with the care package. Examples of risks include: risks from the care environment, safeguarding risks, risks relating to Service User behaviour; and risk assessment tools e.g. speech and language therapy (SaLT). The records must include any specific requirements for managing and mitigating the risks. It should also include contingency plans and escalation procedures for support from other services e.g. GP, secondary care

### **End of Life Care (EoLC)**

The care plan will include details of advance care plans and do not attempt cardiopulmonary resuscitation (DNACPRs)/advance decision to refuse treatment (ADRT) where applicable.

### **Additional Care**

The Provider will notify the Commissioner to agree additional care in advance, using the Contract Variation process defined in General Condition GC13, or as defined by the Commissioner. 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.

Any amendments to the variable elements of the NHS Standard Contract Terms & Conditions will be agreed in advance using the process defined in GC13 and (where applicable) the Individual Placement Agreement (IPA) which will be reviewed as part of the Service Users review.

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 additional care provided that the Provider notifies the Commissioner in writing by the next Operational Day attaching an evidence based report detailing why the additional care was needed to meet the Service User's needs. Such situations include emergencies or sudden significant changes in the Service User's condition.

### **Care Package**

The Provider will agree to deliver a care package in which every Service User will receive an individual, person-centred care package that is within the scope of the services that the Provider can deliver. The appropriateness of the care package will be decided by the Commissioner, informed by input from the MDT and the Provider.

### **Staff**

The Provider will maximise Staff continuity to ensure the stability and sustainability of the service, and to build trust within the package.

If Staff are repeatedly late to a care session, the Service Provider will consider replacement of the Staff member as long as this is not to the detriment of the Service User's experience; if the Staff member is repeatedly late, this must be formally reported to the Commissioner.

The Provider must maintain a monitoring schedule to ensure that contacts are being managed effectively, as defined in the Care Plan and at the agreed times.

Staff must not use mobile phones during a care session, unless directly related to work.

If the Staff member does not attend a care session, the session will not be paid for by the Commissioner.

Staff will respect the fact that the care environment is the Service User's home. Staff will be sensitive to that environment and its contents.

Staff 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 Staff 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.

### **Service Users Home**

The Provider is responsible for ensuring a safe working environment for Staff. As part of the risk assessment, the Provider will minimise and mitigate risks. The Provider will enable Staff 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 Staff exposure to smoke. Additionally, Staff may choose not to work in a smoking environment and the Provider will support this decision without penalty.

### **Service User Equipment**

All carers must be appropriately trained in the use of 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.

All specialist equipment specified in the Agreed Health Outcome 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;
- alert the Commissioner to this need;
- not be responsible for the cost of maintenance;
- ensure that a stock of consumables is held which is sufficient to last the service user 6 weeks, and notify stock replenishment requirements to the Commissioner on a monthly basis, or as agreed with the Commissioner.

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.

### **Provider Supplied Equipment**

The Provider will provide personal protective equipment that meets prevailing standards and the defined need.

The provision of all personal protective equipment and consumables is the responsibility of the Provider. This includes, but is not limited to:

- single use disposable gloves;
- single use disposable aprons;
- 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.

### **Medication**

The Provider will:

- 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 and 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 regulations
- include clear procedures for giving medicines
- Have a default policy of administering medicines from original packs
- Follow NICE <https://www.nice.org.uk/guidance/NG67>

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 (or other Specialist) six monthly or more frequently as required.

### **Records Management**

In addition to the Care Plan and the complaints log, the Provider will maintain the following records:

*Service User Guide* – The provider will make the service user guide available and accessible to the Service User. The guide as a minimum will include the Provider's complaints and feedback procedures, contact details for the provider (including out of hours), contact details for CQC, Service User rights and Provider obligations; Staff procedures and policies, Safeguarding contact details for the Provider; Dorset CCG contact details; and an explanation as to how personal information will be used.

*Care Activity Log* - The log details the delivery of the care plan through all care provided to the Service User during each care visit. This record will be standardised and includes as a minimum:

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

The Provider will complete the care activity log on each occasion that care is delivered. A Provider supervisor or manager will review the care activity log as required by relevant legislation and/or guidance in force at the time of service delivery.

*Staff Training Log* - The Staff training log will record all qualifications, training and induction sessions received by Staff, including training from district nursing teams. 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 Staff training log as necessary and share it with the Commissioner as requested. Staff must be trained to deliver the support tasks required, with the list of all appropriate training specified in the training log.

## **Resuscitation and Medical Emergencies**

The Provider is required to ensure that where the package of care identifies that the Service User may require resuscitation appropriately trained and qualified individuals will be provided

### **Interruption to Care – Provider**

The Provider is responsible for informing the Commissioner when care has not been delivered due to the transfer of the service user to another Service Provider within 24 hours of the aborted visit. The Provider must inform the Commissioner within 12 hours if they have not been able to deliver the package of care due to circumstances which are within the control of the Provider (e.g. non – attendance of Staff). In these cases, the Provider will provide a written explanation to the Commissioner and the Commissioner reserves the right to adjust payment accordingly

### **Interruption to Care – Non-Provider**

Where the Provider receives more than 24 hours' notice of an interruption to care outside the Provider's control no payment will be made. In these instances, the Provider will inform the Commissioner, and adjust the care invoice accordingly.

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 will pay the cost of care for that day, but not for subsequent days.

### **Hospital Stays**

In the event that the Service User is admitted to hospital whilst the Provider's staff are in attendance, the Commissioner will fund a 4-hour handover period at the date and time of transfer to enable the Provider to safely hand the Service User over to the hospital staff. The Commissioner may at its discretion fund a period of up to 5 calendar days, commencing on the date and time of admission where the Provider can evidence that the relevant Staff could not be reallocated to another Service User.

The Provider will cease to deliver the Services to the Service User during the Service User's hospital stay. The Provider will not invoice the Commissioner for Services that are not delivered.

### **Termination of Services**

Where an individual package of care has been arranged for a fixed period, the arrangement shall cease on the expiry of that period. The arrangement may be renewed for a further fixed period with the agreement of the Service User, the Commissioner and the Provider.

The Provider or the Commissioner shall give not less than four weeks' notice to terminate an individual package of care, unless the continuation of the package of care would give rise to a serious risk to the life, health and well-being of the Service User, or other Service Users, in which case the arrangement will be terminated as agreed between the Provider and Commissioner.

It is essential that providers work in collaboration with the commissioning authority with a clear focus on the best interest of the individual. In such cases where the minimum 28 days' notice is insufficient to plan and prepare appropriately to safely transfer an individual's support to an alternative provision, the commissioning authority will expect



providers to work flexibly and in partnership with the commissioning authority to ensure the best interests of the individual remain at the centre of any decisions made.

Where the package of care is no longer required following an assessment by the Commissioner, the Commissioner shall give the Provider one week's notice of the termination of the package of care.

**5. Applicable quality requirements and CQUIN goals**

**5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**

**5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

**6. Location of Provider Premises**

**7. Individual Service User Placement**