

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	11J-CT-03389
<b>Service</b>	Complex Continuing Healthcare
<b>Commissioner Lead</b>	Paul Rennie
<b>Provider Lead</b>	Richard MacMillan
<b>Period</b>	2013/2016
<b>Date of Review</b>	30-03-2015

#### 1. Population Needs

##### 1.1 National/local context and evidence base

This document sets out the specification and quality standards of service delivery that apply to the provision of Complex Care to the adults, children and young people within the county of Dorset who are assessed as being eligible to receive services under the Continuing Healthcare Criteria, or assessed as being Children In Need (CIN) and/or Looked after Children (LAC) or any other eligibility criteria relating to NHS funding.

This service is commissioned in line with the NHS Dorset Clinical Commissioning Group (CCG) and Dorset Children’s Partnership Commissioning Strategies and reflects corporate priorities.

Emphasis will be placed on the promotion of independence and the achievement of positive outcomes for the patient.

#### 2. Outcomes

##### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	

##### 2.2 Local defined outcomes

Complex Care will include the provision of a care team, management of the care provision and may also include the ordering, maintenance and disposal of specialist equipment, ancillary supplies, prescription management any or all of which may be required by the individual patient and will be set out in their care plans. The majority of patients will have severe complex health

needs or a significant disability or/ and an additional mental health need that impacts upon their daily lives. However, the service may also be required to support families experiencing a range of difficulties in delivery of care.

The services will primarily be available to patients in their own living location; however there will be occasions where the care package will be provided in an alternative environment.

In relation to children and younger adults the service will assist in the development of life skills as defined by Every Child Matters (ECM) and supports the inclusion agenda.

The service assists the CCG in meeting key strategic targets e.g.:

- I. National Standards Framework Standard 8 - Disabled children, young people and those with complex health needs.
- II. National Standards Framework Standard 9 - The mental health and psychological wellbeing of children and young people.
- III. Keeping children local and home with their families

Children and young people are defined as from age range birth to 18 years assessed as eligible for Continuing Healthcare needs. This includes children registered with a Dorset GP, up to 19 years of age and, where appropriate and agreed by the commissioner, beyond 19 years, with Continuing Healthcare needs and or short term life expectancy.

For the purposes of this specification, parental responsibility (where applicable) will be determined prior to the initiation of the individual service. Neither the provider nor any member of the care team will assume parental responsibility.

Adults are defined as from age range 18 years and over, assessed as eligible for Continuing Healthcare needs registered with a Dorset GP.

The direct care and support will be delivered by the provider as agreed jointly with the NHS Commissioner and in accordance with the individually assessed needs. The staff will provide care through a planned rota, but flexibility according to patients needs will be applicable.

All services provided shall meet or exceed the double National Minimum Standards for Domiciliary Care. It is a requirement that, where applicable, the service provider(s) will be registered with the relevant regulatory body such as the Care Quality Commission (CQC), Office for Standards in Education, Children's and Skills (Ofsted), or NHS Supply Chain. All service providers will remain registered with appropriate regulatory body throughout the duration of this contract.

Failure to maintain current registration will automatically exclude a service provider from delivering the service under the terms of the contract.

Patient focused outcomes will be agreed with the Commissioner in line with National, and local policy, and guidance alongside patient and representative's own choices in care outcomes.

The NHS Commissioner and The Provider are committed to developing and providing a range of Complex Healthcare Services in order to promote optimum healthcare provision. The NHS Commissioner and The Provider will work within a blameless culture, in a spirit of consultation, co-operation and partnership to ensure that services are available to effectively meet the needs of the eligible population of Dorset. Effective risk management, open communication and learning will be the favoured methods to achieve this. This specification applies to services provided by the NHS Commissioner and The Provider.

The NHS Commissioner and The Provider recognise the need to provide an empathetic service. To achieve this there needs to be mutual understanding and respect between the Provider's care team and the patient's family and/or representatives.

### 3. Scope

#### 3.1 Aims and objectives of service

##### Aims

The aims of the service schedules are to:

- Enable the adult, child or young person of Dorset (who have been assessed as eligible), to remain living in their own homes for as long as is practicably possible and clinically appropriate. This will be achieved by maintaining and/or enhancing their quality of life and promoting and maintaining standards of health, hygiene, safety and comfort in their home, provided in such a way as to complement the existing range of community services.
- Support informal and formal carers with provision of relief and respite care at times and in a manner that suits them and the patient and minimises any further disruption to their lives as agreed by the NHS Commissioner.
- Provide responsive complex care services that are patient and family focused, by providing a range of flexible, responsive, child and family orientated, co-ordinated services, from highly complex interventions to lower level complexity nursing support and domiciliary and short breaks.
- Provide services within the patient's own living location, which are compatible with the individual's circumstances and lifestyles of the household. This means providing services in the least obtrusive way in order to minimise any disruption to the patient and family.
- Address the policy standards and legislation relating to this cohort of patients.
- Promote social inclusion and enhance the life chances of people.
- Attend or access services such as cultural, spiritual, leisure and practical needs and where appropriate educational needs.
- Provide specialist home care services required by disabled persons and those with complex medical health needs that meet their physical and emotional needs;
- Ensure patients are treated as individuals and their opinions listened to. All decisions about patients should take account of their wishes.

##### Objectives

The level of service will be defined and commissioned by the Commissioner in relation to three levels of intervention dependent upon the complexities and intensity of need as detailed in the patient's care plan.

The levels of care may be mixed within the same care package to provide the appropriate care within suitable periods throughout the day.

The direct care and support will be delivered by The Provider as agreed jointly with the Commissioner and in accordance with the individually assessed needs. The Providers staff will provide the appropriate level of agreed care through a planned rota whilst at the same time demonstrating flexibility according to patient need.

Specific qualifications, competencies and skill mix required will be agreed between The Provider and the NHS Commissioner on a case-by-case basis prior to the commencement of the recruitment process, for each care package.

LEVEL OF  
NEED

INTERVENTIONS (LIST NOT  
EXHAUSTIVE)

NEEDS (LIST NOT EXHAUSTIVE)

<p><b>HIGH</b></p> <p><b>Maximum Lead in time 6 weeks</b></p>	<ul style="list-style-type: none"> <li>• Intravenous infusions</li> <li>• TPN</li> <li>• Central lines</li> <li>• Tracheostomy and ventilatory support night and day 24/7</li> <li>• Haemodialysis</li> <li>• Ventilatory support either night or day</li> <li>• Complex Continence care</li> <li>• Dialysis</li> <li>• Medications management complex – intrathecal and other routes</li> <li>• Complex Tissue Viability</li> </ul>	<p>Complex respiratory and airway management where airway management is not stable.  Long term complex nutritional management  Life limiting and life threatening conditions requiring immediate response by a trained nurse.  Problematic continence management outside of mainstream services.  Pain and symptom management requiring clinical judgement outside of a prescribed regime for example a seizure protocol or rescue medication regime  Manual Handling constraints bespoke equipment with risks to underlying condition  Palliative-End of life care not met by routine care or input from the General Palliative Case services or district nursing services  Specialist and frequent dressing requiring analgesia, within a pain and symptom management plan.  Severe communication needs  Challenging behaviour requiring a management plan</p>
<p><b>MEDIUM</b></p> <p><b>Maximum Lead in time 2 weeks</b></p>	<ul style="list-style-type: none"> <li>• Routine Tracheostomy and ventilatory support night and day 24/7</li> <li>• Ventilatory support either night or day – oxygen, nebulisers and suction</li> <li>• Non ventilatory dependency with stability /predictability</li> <li>• PEG feeding/dysphagia</li> <li>• Stoma management</li> <li>• Medications management</li> <li>• Naso gastric feeding</li> </ul>	<p>Respiratory and airway management- airway is stable and requires predictive management</p> <p>Nutritional management predictable but with some risk when providing nutrition  Continence requiring routine care  Medication administration to a predictable regime oral/rectal routes- seizure protocol where patient responds to rescue medication.  Tissue viability – non-complex management and wound is responsive to treatment.</p> <p>Mobility issues within a risk management plan.</p>
<p><b>LOW</b></p> <p><b>Maximum lead in time 48 hours</b></p>	<ul style="list-style-type: none"> <li>• Medication</li> <li>• Nutritional</li> <li>• Tissue viability</li> <li>• Continence</li> <li>• Communication</li> </ul>	<p>The nature and characteristics of the condition are stable and predictable.</p> <p>Low level seizure management, monitoring/ observation Medications administered via non-complex routes.</p> <p>Non problematic gastrostomy</p> <p>There is requirement for low intensity, predictable interventions which can be provided by a trained and competent carer.</p> <p>Non-complex wound management</p> <p>Minimal mobility risk.</p> <p>Routine Continence management</p> <p>Prompts to aid communication.</p>

### 3.2 Service description/care pathway

A clinical nursing service that provides a range of service models from high intensity complex care packages to medium and lower level domiciliary care services for eligible adults, children and young people, employing competent qualified nursing and care staff (including children's nurses where appropriate to the package) and trained, competent carers to provide skilled and timely interventions and care to patients in a home environment, or similar e.g. family based shared care

setting. The patient will receive a consistent service in relation to the individual's changing environments and needs.

The patient's overall care package will be instigated and maintained by a consistent workforce within the agreed time frames by staff who individually and collectively, have the skills, competence and experience to deliver the services and care interventions identified within the care plan.

For the purpose of these standards, home environment refers to the provision of support to the patient primarily in his/her living location; however there will be occasions where the care package will be provided in an alternative environment and the provider will be able to meet this requirement.

The service will be provided to align with three differing levels of care as specified and agreed within the patient care plan. The levels of care may be mixed within the same care package to provide the appropriate levels of care within suitable periods throughout the day.

The service may provide nursing, personal and other associated care, specialist equipment, disposable and ancillary supply and prescription management as identified in the care plan for the patient and to be identified and agreed in writing by both the Commissioner and the Provider.

The direct care and support will be delivered by The Provider as agreed jointly with the Commissioner and in accordance with the individually assessed needs. The staff will provide the appropriate level of agreed care through a planned rota, whilst demonstrating flexibility according to patient need.

### **3.3 Population covered**

The service will be provided to patients who are registered with a GP within the Dorset County only.

### **3.4 Any acceptance and exclusion criteria and thresholds**

#### **Care levels and Dependencies**

The service will be determined by the level of care required. The following descriptors are a guide only.

A **High** level of dependency will be commissioned when some or any of the following applies:

- The case management of the adult, child or young person is clearly defined.
- There are complex and intense tissue viability needs which require analgesia and ongoing pain and symptom management
- Mechanical and technological intervention is required
- Medications require significant adjustment by the practitioner according to fluctuating conditions or require complicated administration regimes/ routes such as intravenous or intrathecal
- There is a mobility risk as a consequence of an underlying condition.
- The levels of unpredictability evident or characteristic of the condition and/or behaviour are such that they present an increased risk to the carer or child/young person
- Nutritional requirements necessitate intravenous therapy such as total parenteral nutrition (TPN).

A **Medium** level of dependency will be commissioned when some or any of the following applies:

- There is a stable airway requiring predictive management such suction, oxygen, nebulisers
- There is a higher than usual level of risk when providing nutrition e.g. naso-gastric tube.
- Tissue viability – the wound is responsive to treatment.
- Medications, although complex, are predictive and there is client compliance.

- There are mobility issues for the carer which have been risk assessed.
- There are unstable elimination issues.
- Socially challenging high risk families/environments

A **Low** level of dependency will be commissioned when some or any of the following applies:

- The nature and characteristics of the condition are predictable and responsive
- There is Community Children's/Adults Nurse Case Management involvement and lead professional role
- There are low level and predictable interventions which can be provided by a trained and competent carer.
- Medications are administered via non-complex routes under parental responsibility.
- Wound management is of a low level complexity regime.
- There is minimal mobility risk.

The following table is linked to national domains and represents the three Dependency levels but the examples are not exclusive and are for individual case discussion with the Commissioner.

DOMAIN AND DESCRIPTOR	DEPENDENCY LEVEL		
	High	Medium	Low
<b>Challenging Behaviour</b>	Behaviour requiring specialist health interventions and posing a risk to the physical safety of the person and/or carer	Behaviours that require multi-agency involvement and where an adolescent is unable to self-regulate their behaviour, including impulsive behaviour and self-neglect	Behaviour that is predictable and can be managed by a skilled carer
<b>Communication</b>	Barely able to communicate despite support from carers and professionals and/or the young person demonstrates severe frustration through challenging behaviour at being unable to communicate.	Basic needs are difficult to interpret or anticipate. Support with communication aids is usually required	Special effort required to anticipate and interpret needs
<b>Mobility</b>	Completely immobile and unstable clinical condition where movement presents a high risk of serious physical harm	Unable to move in a developmentally appropriate way and unable to assist. Needs more than one carer.  Involuntary spasms placing self or carer at risk.	Unable to stand but can assist with one carer. Some sleep deprivation due to underlying medical needs 3 times per night for at least 2 nights per week

		Extensive sleep deprivation 1-2 hourly 4+ nights per week	
<b>Nutrition</b>	IV feeds – TPN  Severe dysphagia with associated risk of aspiration/choking.  On going skilled assessment required.	Specialised feeding plan.  Naso gastric feeds  Problematic Gastrostomy/jejunostomy	Non-problematic gastrostomy/jejunostomy  Requiring dietary support/advice because of underlying condition
<b>Continence/ Elimination</b>	Requires peritoneal/haemodialysis to sustain life.  Problematic stoma care.  Problematic continence care – e.g. Intermittent catheterisation by skilled carer.	Doubly incontinent but with routine care  Self-catheterisation  Occasionally unstable stoma	Routine continence care with pads, etc.  Stable stoma.
<b>Skin/Tissue Viability</b>	Life threatening skin conditions or burns.  Unresponsive open wounds.  Requires specialist dressing regime.  Active condition requiring daily monitoring and treatment	Responsive open wound.  Active skin condition requiring minimum of weekly clinical reassessment.  High risk of skin breakdown requiring preventative intervention several times per day from skilled carer.	Pressure or minor wound requiring clinical reassessment less than weekly.
<b>Breathing</b>	Requires mechanical ventilation either permanently or just when asleep.  Highly unstable tracheostomy with frequent occlusions requiring suction and difficult to change tubes.  Frequent unpredictable apnoeas requiring oral and/or naso pharyngeal suction	Requires use of intermittent or continuous low level oxygen and/or oral suction.  Has episodes of acute breathlessness requiring clinical input	.Requires assistance with use of inhalers and nebulisers.

<b>Drug Therapies and Medication</b>	<p>Intractable pain requiring medical and nursing management to ensure effective pain and symptom control.</p> <p>Extensive sleep deprivation causing severe distress due to intractable pain.</p> <p>RGN required for drug management.</p>	<p>Skilled carer required for drug management.</p> <p>Sleep deprivation due to essential medicine management occurring at least 4 times a night 4 times a week.</p>	<p>Sleep deprivation due to essential medicine management occurring 2-3 times a night at least twice a week.</p>
<b>Psychological and Emotional</b>	<p>Rapidly fluctuating moods of distress, anxiety and depression necessitating specialist intervention.</p> <p>Total withdrawal from daily activities.</p> <p>Risk of self-harm or symptoms of mental illness, placing the young person at risk.</p>	<p>Frequent low mood/depression with noticeable fluctuations in concentration.</p> <p>Withdrawn and limited response to necessary prompts.</p> <p>Noticeable deterioration in self-care requiring prolonged intervention from key staff.</p>	<p>Occasional anxiety/low mood.</p> <p>Responds to prompts and reassurance.</p>
<b>Seizures</b>	<p>Requires daily intervention and clinical judgment by RGN to select and implement appropriate interventions to manage the seizures.</p> <p>Severe, uncontrolled seizures not responding to medication and treatment within a protocol.</p>	<p>Seizures resulting in loss of consciousness.</p> <p>Skilled intervention required within a protocol</p> <p>Sleep deprivation due to essential seizure management occurring 3 times a night.</p>	<p>Occasional seizures or periods of unconsciousness requiring supervision by a carer to reduce self-harm.</p>

### 3.5 Interdependence with other services/providers

Stakeholders and interdependencies will vary as identified above and the interface with universal services cannot be overstated. Access and support from universal services should be sought as circumstances allow

The service will demonstrate clear knowledge of how to access local NHS primary and acute services, if required and signpost the patient and their family/representative accordingly.

All patients in receipt of a package of care commissioned through NHS funding will maintain their entitlement to access mainstream NHS services. The Provider shall establish and maintain links with key primary and secondary NHS services that may be involved in the patients overall care provision.

## 4. Applicable Service Standards

### 4.1 Applicable national standards (e.g. NICE)

The services provided will be subject to inspection by the Care Quality Commission



All services will be required to meet the following:

- Care Quality Commission Core Standards and performance indicators
- Standards for Disabled Children who are ill
- Relevant NICE TAG's (Technology Appraisal Guidelines)
- Children Act (2004) section 11 and other safeguarding legislation
- PEAT (patient environment assessment tool)
- All service provision should be delivered in an appropriate, safe, child/young people centred environment, which promotes effective care and optimises health outcomes

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

The NHS Commissioner and The Provider agree to adhere to the multi-agency 'No Secrets' Adult Protection Policy and any other relevant legal frameworks or guidance and other associated policies and guidance including, but not limited to, the following Legislation, National and Local Standards

- The Essence of Care (2001)
- The Mental Health Act (2003)
- HSC 2001/17
- The Care Standards Act (2000)
- Nursing and Midwifery Council – Code of conduct (2002)
- All NMC advice to practitioners.
- Every Child Matters Change for Children Programme (2004)
- World Class Commissioning. DOH 2008
- National Service Framework for Children and Young People and Maternity services (DOH 2004)
- Childrens Act (2004)
- Aiming High for Disabled Children (2007)
- The Operating Framework for the NHS 2010
- The Children's Plan (Department of Children Schools and Families, 2007)
- Standards for Better Health 2004 (in particular Standard 8)
- Better Care, Better Lives 2008
- Darzi Review October 2007
- Our Choice, Our Health, Our Say (2006)
- Transforming Community Services 2009
- The 4 Nations Child Policy Network review 2003-4
- Working together to safeguard children DOH 2006
- HM Government 2007. Statutory Guidance on making arrangements to safeguard and promote the welfare of Children. Updated March 2007. London
- Local LSCB standards
- Relevant NICE guidance
- National Framework for Children and Young People's Continuing Care (2010)
- National framework for NHS continuing healthcare and NHS funded nursing care (2012)

#### **4.3 Applicable local standards**

- Local Safeguarding procedures
- Local Area Agreement
- Local applicable CCG or multi-agency policies and procedures

The service design will contribute to:

- providing clinically appropriate and safe services in the patient's own home or other suitable environment;

- enable the adult population of Dorset who have been assessed as having complex care needs and meet the criteria for specific NHS funding, to remain living in their own homes for as long as is practicably possible and clinically appropriate. This will be achieved by maintaining their quality of life and promoting and maintaining standards of health, hygiene, safety and comfort in their own homes, provided in such a way as to compliment the existing range of community services;
- provide families and informal carers with respite care at times and in a manner that suits them and the patient and minimises any further disruption to their lives as agreed by the NHS Commissioner;
- provide a range of high quality, flexible and responsive, complex care services that are person and family focused, and, to ensure that staff have the flexibility to vary the care provided to meet the changing needs and environment of the patient;
- provide services within the patient's own living environment, which are compatible with the individual's circumstances and lifestyles of the household. This means providing services in the least obtrusive way in order to minimise any disruption to the patient and family;
- promote social inclusion and enhance the life chances of people.
- provide specialist home care services required by disabled persons and those with complex medical health needs that meet their physical and emotional needs;
- provide short break for the principal informal carers of adults who are eligible for NHS Complex care, on a reviewable basis.
- ensure patients are treated as individuals and their opinions listened to. All decisions about patients should take account of their wishes.

The specification seeks to address the community based interventions for adults with complex care or, where agreed by the Commissioner, palliative care needs to improve outcomes for them and their families. Delivery must be in partnership with the patient, family, carers and professionals.

Care providers must:

- listen, identify and meet needs in an individualised and flexible way;
- deliver care for the patient in the most appropriate setting chosen as agreed with the NHS Commissioner;
- deliver to agreed individual care plans, including planned pain and symptom management, as set down by lead professionals working with the patient;
- ensure cultural, spiritual and practical needs are considered and incorporated into care plans;
- Support patients to access services such as appropriate.
- The Provider will ensure continuity of the service for the person receiving the care and/or support by arranging a regular service from the same support worker(s) wherever possible.

The Provider is required to refer to the appropriate NHS Case coordinator immediately any significant changes or events that comes to their attention in the person's circumstances. The

Provider shall also liaise with other care and medical contractors as necessary to ensure a co-ordinated approach.

### 1.3 Patient choice

The services shall be provided by the Provider in accordance with the service specification, the following details are not therefore exclusive:

- The NHS Commissioner and the Provider shall ensure that the patient is offered a suitable and consistent care package, which meets the assessed needs as specified in the patient's care plan;
- Patients shall be helped to exercise informed choice and control over their lives in accordance with the agreed holistic needs assessment and therefore supported in maintaining their independence in the wider community;
- Where the patient is unable to express a preference for themselves, which has been proven through a suitable capacity assessment, the NHS Commissioner shall act on the principles of Best Interest taking into account the preferences expressed by the patient's duly authorised representative or guardian.
- Children will be treated as individuals and their opinions listened to. All decisions about children and young people will take account of their wishes. It is every child's right to be afforded the opportunity to experience self-worth, security and stability. The welfare of the child is paramount.

### 1.4 Care Package Review

In order for the service delivery to be patient focused its is essential that regular monitoring of care needs be undertaken as follows:

Type	Purpose	Minimum Participants	Minimum Frequency	Minimum Agenda Items
Informal	To ensure that the care package is meeting the individual needs	Provider Named Nurse Patient Family	Monthly or less depending on patient and/or representative choice.	Review of care needs Communication and feedback Compliments Complaints and concerns Family/team dynamics
Formal	To ensure that the agreed care plan continues to meet the assessed needs	Provider's Case Manager Provider's Lead Nurse NHS Case Coordinator Identified multidisciplinary professionals Patient Family	Annually	Review of latest assessed needs Review of overall care plan Review of clinical needs Review of care package elements and associated contract prices.

Critical/ Emergency	To address where there is a substantive or sustainable change in care needs or identified serious risk of breach.	Provider's Lead Nurse NHS Senior Manager NHS case coordinator Contract Manager as required.	Within 2 working days of the request by either party	Identify and understand the change/risk. Agree and action plan for immediate medium and long term rectification.
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Additional reviews may be undertaken as follows:

- The patient has a right to request a review of the care package at any time. Any such request should be referred to the NHS Case Coordinator who will identify the reasons for such a request;
- The Provider has a right to request a review of the care package at any time. Any such request should be referred to the NHS Case Coordinator who will identify the reasons for such a request;
- If the patient or their representative expresses a view to either the NHS Commissioner or the Provider that their care package is not meeting his/her needs, a review shall be held between all parties. The Care Plan and Letter of Service Contract shall not be amended in any way without the consent of the NHS Commissioner, with agreement from the patient and/or their representative.

## 5. Applicable quality requirements and CQUIN goals

### 5.1 Applicable Quality Requirements (See Schedule 4A-D)

Not Applicable

### 5.2 Applicable CQUIN goals (See Schedule 4E)

Not Applicable

## 6. Location of Provider Premises

### The Provider's Premises are located at:

Caledonia House  
223 Pentonville Road  
Greater London  
N1 9NG

## 7. Individual Service User Placement

### 7.1 Service model Section 1 :

#### ASSESSMENT REFERRAL AND INITIATION OF THE INDIVIDUAL PATIENT SERVICE (THE CARE PACKAGE)

The appropriate eligibility assessment procedures for a patient will be carried out in accordance with the NHS National Framework for Continuing Healthcare Funding and NHS Funded Nursing Care 2007 (Revised July 2012) or other relevant criteria.

The NHS Case Coordinator will be responsible for co-ordinating the assessment of health needs. The Multi-Disciplinary Team involved in that assessment will have working knowledge of patients'

care needs and produce the relevant documentation about how these can be met. This will be an overarching plan of care needs that is shared with the provider on referral.

In accordance with the requirements of the Health and Social Care Act 2001, the Single Assessment Process, where possible, will be used. The patient will be involved throughout the care management process and their wishes taken into consideration. Where a patient lacks capacity to be involved in their care planning, the wishes of the family and/or a representative will be taken into consideration.

The NHS Case Coordinator will seek the consent of the patient and The Provider prior to any referral being made.

### **Referral and Funding Authorisation**

A referral can only be made to the Provider by an employee of NHS Dorset CCG based within the Continuing Healthcare team. The CCG employee may only refer when they have identified an individual patient who is found eligible for NHS Continuing Healthcare funding unless otherwise agreed by the commissioner.

Once a referral has been received, the provider shall undertake an initial assessment of the patient prior to agreeing to provide services. The Provider has an obligation to carry out their initial needs assessment within 3 working days and confirm the outcome of that assessment to the NHS Commissioner within 5 working days of receipt.

The provider shall bring to the attention of the case coordinator any differences in the proposed care plan that are identified by the provider's assessment. Such notification to be made in writing to the Commissioner.

*The Provider will ensure those service users' whose needs have been assessed as 'urgent', receive a service, wherever possible, within five working days of receipt of referral. The type and delivery of that service will be agreed between the provider and commissioner.*

Following the providers assessments the commissioner and provider will agree the patient's care plan.

The Provider shall submit to the Commissioner a quotation of cost in the form of a referral and funding authorisation request for the service to be provided as outlined in the agreed care plan.

The Commissioner will review costs and if any changes need to be made discuss with the provider. Where the quotation is acceptable, the commissioner will authorise and return the referral and funding agreement in order for the provider to commence setting up of the services. Once the package is up and running the commissioner will issue a contract variation letter in the form of a 'Memorandum of Agreement'. These will be signed by both the commissioner and provider.

Where the NHS Commissioner wishes to purchase services for an individual patient under these conditions, a 'Memorandum of Agreement' will be completed by the NHS and signed by the provider, the NHS Commissioner and the patient or their representative. The care plan shall also be signed by the patient or their legal representative and the provider and form part of the agreement.

The Provider must refer any requests for services outside of the agreed care plan, where the patient requires public funding, to the NHS for authorisation. The NHS Commissioner shall not accept responsibility for payment of the provider's contract price for services provided where such authorisation has not been obtained. This must be in writing by both parties.

Providers must be willing to take direct referrals from patients/parents when individual personal health budgets are being used. Providers will need to have agreed unit costs for patients and/or parents and develop a professional working relationship with them as if they were commissioning

their own care provision. The NHS will monitor this relationship and care provision as part of ongoing review processes.

An assessment of patient's needs and any known risk factors will form part of the package request plan. The Provider will be expected to undertake further risk assessments and identify how the referral requirements can be met. It is the responsibility of the provider to link with the referrer to discuss any issues of concern.

All known relevant information will be given to the provider. This will include an assessment following the eligibility decision and agreed care package stating number of hours to be provided and how.

The provider will confirm in writing when the arrangement is due to start and how the package will be delivered.

### **Refusal of Referral**

The Provider shall only have the right to refuse to accept a patient who is referred to the service if any of the following apply:

- i. The patient in question is not eligible for the service;
- ii. The Provider can demonstrate there are reasonable grounds to believe the acceptance of the referral would create a significant danger for staff, or the improper functioning of the provider;
- iii. Before refusing any referral, the provider should advise and consult with the responsible referring commissioner.

### **Individual Service Initiation**

On receipt of an authorised referral and variation form, The Provider will initiate a specific care package set up which may include a recruitment campaign.

### **Recruitment Process**

Through its stringent recruitment practices, The Provider undertakes to identify and provide a team of appropriately skilled staff to deliver the care required in accordance with the care plan set by the commissioner. All staff must be able to communicate in English both in writing and orally, with a minimum standard of 6.5 to 7 using the 'International English Language Testing System' (IELTS) or equivalent and have basic numeracy skills.

### **Experience Criteria**

Specific qualifications, competencies and skill mix required will be agreed between the provider and the NHS commissioner on a case-by-case basis prior to the commencement of the recruitment process, for each care package.

### **Timeframes**

It is recognised that the timeframes for setting up individual packages of care will vary considerably. It is expected that more routine packages of care will be recruited to quickly and that those with more complex needs will take longer. The time frame for each recruitment campaign will be agreed between the NHS commissioner and the provider at the point of referral. There may be occasions when patients or their representatives may wish to add input into the recruitment of staff and agreement of timeframes for mobilisation of a care package. The provider

and commissioner will take this into account on an individual basis, but this input should not add any delay to the commencement of any care package.

### **Staff Orientation and Training**

In order for the patient to receive a seamless service in the transition from hospital care to primary care it is vital that the staff are able to orientate and work with the patient and family in both settings.

Following the appointment of the team the provider will initiate a specific orientation and training programme.

For the duration of intervention, whilst the patient receives in-patient care, the staff provided by The Provider will work:

- Under honorary contracts organised by the acute trust and provider.
- Under the guidance of the provider assigned case manager.
- Under the guidance of a clinical lead identified by the acute trust and who has responsibility for the welfare of the patient during the inpatient phase.

### **Discharge/Transition Planning**

Effective planning is key to the successful transition of care from the acute to the primary setting and/or service provider. The process should be initiated as soon as practicably possible after the funding has been put in place.

The provider will nominate a discharge/transition planner. This person will project manage the discharge/transition process and liaise with all the parties involved including the patient's family, the acute staff and primary care staff to ensure that communication channels are correctly established.

### **Discharge Timetable & Risk Sharing**

Notification from the Authority to The Provider of a patient meeting complex care criteria following referral shall be considered day 1 (one) of the discharge planning.

Formal notification of referral will be made using a referral form sent by the appropriate NHS Care team.

Risk sharing is where the patient is discharged on the agreed date and the package is not fully staffed by the provider and agency staff must be utilised.

Only in exceptional circumstances such as 2 (two) or 3 (three) patients being discharged simultaneously would risk sharing be invoked.

The risk sharing period will last two months.

- For the first month any costs incurred over and above The Provider's hourly staff rate will be met on a 70:30 basis by the NHS commissioner and provider.
- For the second month any costs incurred over and above the contractor's hourly staff rate will be met on a 50:50 basis by the NHS and the provider.
- For the third month onwards the full cost of the staffing will be met by the provider.

All Risk Sharing agreements are to be agreed with the relevant NHS commissioning managers. The provider will report on a monthly basis all additional costs incurred to the commissioner.

### **Multidisciplinary Involvement**

In order to address the complex needs of this particular patient group, a multidisciplinary approach must be taken. Whilst The Provider will ensure that the nominated discharge/transition planner is available to all members of the team the NHS must ensure that all key personnel involved in the care of the patient are identified and available for this process.

Key personnel/disciplines identified within this contract are:

<b>The Provider</b>	<b>Acute Trust</b>	<b>Primary Care Team</b>
Registered Manager	Lead Consultant	Key Worker
Case Manager	Lead Nurse	NHS Case Coordinator
Community Nurse		

### **Training of Family carers**

The referring case coordinator or NHS trust will train and consider competent those persons deemed appropriate in agreed aspects of patient's clinical care prior to discharge and/or as an ongoing programme of training.

For children the training of family/informal carers is undertaken by CCN's (Children's Nursing). For adults training will be provided by the responsible clinician.

### **Record Keeping**

**Nursing documentation will be agreed jointly by the NHS commissioner and the provider and supplied by the provider in line with the Nursing & Midwifery Council Code of Conduct on Record Keeping.**

A full copy of the patient's care records, including medical history, care plans and risk assessments, will be available in the patient's home together with a plan of the care to be provided. All nursing and care interventions will be recorded in the documentation provided.

To maintain continuity of care, staff supplied by the provider will undertake their duties in accordance with the care protocols and as agreed by the NHS with all interventions to be agreed by the commissioner and provider.

At the end of the care package, The Provider will forward all patient records to the commissioner whilst retaining a copy for their own records and in accordance with their legal obligations.

### **Staff**

#### **Staff training**

The patient's overall care package will be instigated and maintained by a consistent workforce within the agreed timeframes by staff that individually and collectively have the skills, competence and experience to deliver the services and care identified within the care plan. The patient receives a consistent service in relation to changing environments and needs.

#### **STAFF TRAINING PROGRAMME - to include as a minimum:**

First aid

Fire safety

Incident recording

Documentation

Manual handling



Admin of medication
Violence and aggression
Safeguarding
Confidentiality and data protection
Complaints procedure
Health and safety
Restraint
Anti-discriminatory practices
Communication skills
Managing challenging behaviour
Working with parents
Clinical Governance
Nursing procedures (for untrained staff with regular assessments)

- Training will be provided in accordance with the statutory requirements of registered domiciliary providers. This list is not exhaustive. For higher levels of intervention a greater degree of competence is required and will be reflected in additional training.
- Competency based staff training and development that takes account of physical, environmental, social and cultural, religious needs and preferences of the patient.
- Staff training and development records detailing a suitable induction programme and appropriate mandatory updates

### 3.6 Staffing Levels

- The Provider shall recruit, induct, train, supervise and support all staff that will provide the service within the context of a staff development programme.
- The service provider shall provide the CCG with details of the management and staffing structure that it intends to use to provide the service, which must be adequate to achieve the level and standard of service required by this service specification.
- The service provider shall have a rigorous staff recruitment and selection procedure, which meets the requirements of all relevant legislation and ensures protection of service users. This procedure will ensure that Full Enhanced Disclosure and Barring (DBS) checks are undertaken at the appropriate level for any staff recruited, selected, or already working with vulnerable adults and children. These checks should be carried out every two years thereafter.
- Under the vetting and barring scheme Employers and volunteer service providers that deal with children and vulnerable adults must always check a person's Independent Safeguarding Authority (ISA) status before employing them. Employers cannot employ

staff and have them in post – even supervised – before they know the outcome of the ISA check.

- There is to be no occasion where a person without a clear, enhanced DBS check is allowed to work on the service in contact with any patients, unless otherwise agreed by the commissioner.
- All staff will be expected to have an understanding of the principles of disability equality and some experience of working with disabled people.
- All staff will be offered the opportunity to undertake a relevant NVQ or equivalent professional qualification
- The service provider shall take all practical steps to ensure its staff group is representative of the community served by the commissioner.
- The provider will make every effort to recruit support staff to reflect the diversity of the service user group.
- All staff undertaking health related care under Level 3 will ensure that they are appropriately trained, competent and safe to undertake any procedure required in the care plan and will identify any ongoing training needs as required. Ongoing competency will be reviewed and formally recorded as appropriate.

### **Staff Support**

- Trained staff and carers will receive clinical supervision from their care manager
- Assessment of clinical competence / confidence will be reviewed on a regular basis to be determined by the provider.
- Professionals will also meet monthly with their manager for theoretical and emotional support where needed.
- Staff will have once yearly performance reviews or agreed development plans
- All staff will be supported to develop career progression pathways
- Clinical planning will be updated regularly at agreed intervals
- Access to counselling if required.

### **Staff Sickness**

In the event of staff sickness, The Provider will use all reasonable endeavours to ensure that the shift is covered by an alternative member of staff. *Priority will be given to the night shift if this is a requirement of the overall care package.* In the event that there are no available staff, judgements will be made on an individual basis as to:

- The ability of the family/parents to undertake the care in the short term (3 consecutive shifts or less)
- The feasibility of re-negotiating shift patterns so that there are agreed periods where a member of staff will not be on duty (for a 3 – 7 day period)
- The need for the patient to be re-admitted.
- The implementation of the care package contingency plan.

The NHS Commissioner must be informed of any shifts which can not be covered and details of remedial actions taken on the same day or next working day if at a weekend or Bank Holiday.

### **Sub-contractors**

The Provider must notify the CCG if it intends to use subcontractors when delivery of care cannot be met through the organisation's own service capacity. If nursing agencies are used to augment capacity then the Provider must provide the CCG with details of these agencies. Any use of agencies will be at no *additional* cost to the commissioner.

### **Extraordinary cover**

In the unlikely event that The Provider is unable to meet the ongoing requirements of the care package due to an acute shortage of personnel, the NHS Commissioner may allow The Provider to sub contract. However, this will need to be agreed in writing by the CCG at the time. Up to four shifts may be subcontracted in an emergency without specific written authorisation by standing agreement with the funding authority.

An acute shortage of personnel may also arise in the case of an epidemic outbreak of sickness amongst team members.

In both instances, The Provider is responsible for bringing to the attention of the NHS Commissioner, at the earliest available opportunity, any situation that may hinder the long term staffing of the care package. The Provider, the parents/carer and the NHS Commissioner will then agree a course of action.

### **Emergency Situations**

Informing the emergency services of the patient's circumstances prior to discharge and also the utility companies that medical equipment is in use in the patient's home is the responsibility of The Provider

All staff supplied by The Provider will be trained in basic life support and airway management.

Prior to discharge/transition an environmental risk assessment and recommendations will be made by The Provider in conjunction with the NHS Commissioner.

### **Clinical Emergency**

Basic resuscitation equipment for those with artificial airway i.e. re-breathing bag, portable oxygen, suction and spare tracheotomy tubes will be available at all times including when the Patient is on outings away from the home environment.

The Referring Unit will be responsible for providing initial emergency intervention training in relation to patients with artificial airway to the Patient/ Parents/Guardians/Carer according to the accessed needs.

In the event of a clinical emergency the emergency services will be contacted by dialing 999. The patient will be accompanied to the nearest A&E department by the member of staff on duty. The member of staff will also ensure that the necessary medical equipment is taken with the patient to the hospital. The Parent/Guardian/Carer may choose to go in the ambulance with the patient (need to change this) or follow on behind.

### **Environmental Emergency**

All equipment must have the capacity to function via battery in addition to mains power.

A hand held torch and rechargeable battery powered lantern will be available throughout the length of the care package and supplied by The Provider.

The utility company will be contacted by either The Provider staff member or an adult member of the household to ascertain the approximate length of the power failure.

A risk assessment will then be made taking account of the needs of the patient, the battery life and the potential length of the power failure and the actions to be taken.

The Provider's Care Staff will notify the relevant NHS department as soon as possible if in normal working hours and on the next working day if a weekend or a Bank Holiday to agree action plans.

Other emergency situations will be deemed as Adverse/Critical Incidents and dealt with accordingly and shared with the Provider at the time.

### **Equipment Provision and Maintenance**

In order for the patient to be cared for safely in the home it is essential that all equipment is readily available. The exact requirements will be assessed as part of the discharge planning process.

Two pieces of the essential items such as ventilators will be provided in case of equipment failure. Only persons deemed competent will use the equipment. All equipment will be checked on a daily basis and any faults reported.

The Provider will keep a list of all equipment with details of provider, manufacturer, emergency contact number in case of failure and details of service history, in the patient's home.

#### **Hardware**

***It is envisaged that the Provider will work in partnership with the CCG and deliver a flexible service to meet patient needs, in particular those with regards to equipment.***

***The CCG requires the Provider to understand the complexity of equipment needs for this patient group and recognise that, in the purchase of equipment, the maintenance and removal when necessary will be different for each patient.***

CCG will:

- Provide or contract where able all necessary equipment for the Patient;
- Provide the team with a mechanism for emergency replacement both in and out of hours. In the event that a replacement cannot be obtained The Provider will endeavour to provide a substitute that will be liable to a delivery and rental charge.
- All equipment will remain the property of the CCG who will be responsible, when it has purchased the equipment, for its removal when no longer required. .

The Provider will, when required:

- Provide all contracted equipment for the patient to the CCG on a rental basis where needed.
- Provide an emergency replacement service 24 hours/day where this is not contracted for by another agency
- Routinely service and maintain the contracted equipment.
- All equipment will remain the property of The Provider, when it has purchased such equipment, who will be responsible for its removal should the care package cease.

#### ***Disposable Equipment and Ancillary Items***

Stock levels and the supply of disposable equipment and ancillary items will be agreed prior to discharge together with a mechanism for re-ordering. As with medical equipment The Provider is required to demonstrate flexibility when considering the ordering, collection and use of disposable equipment.

The Provider must be aware that there are different policies relating to disposable equipment across the Dorset County and The care Provider must be aware of these processes and ensure its staff are educated in CCG policies.

The CCG will:

- Provide all agreed disposable equipment and ancillary items relating to the patient, where local arrangements allow.
- Agree a routine stock take and delivery schedule with the Provider individualised to each care package.

The Provider will:

- Provide all agreed ancillary equipment and disposable items with the costs to be borne by the Authority, where local arrangements do not allow this equipment to be sourced elsewhere.
- Agree a routine stock take and delivery schedule with the Patient's family that has been approved by the CCG.
- Provide an emergency supply service in the event of an unexpected increase in usage
- Monitoring and reporting of usage will be undertaken by The Provider and reported to the CCG as part of contract monitoring.
- Provide any ancillary equipment relating to their staff and their protection and health and safety guidance with the costs to be borne by The Provider.

### **3.1 Service model Section 2 :**

#### **ONGOING SERVICE PROVISION**

The service model comprises of a team leader/supervisor with the relevant skills and qualifications in line with the Providers statutory obligations under its registration, and a team of qualified nurses and trained carers with a:

- Named key worker identified for each patient.
- Clear system for handover of information re Adults or young person's specific needs from key worker/named nurse, in place.
- Documentation and recording systems
- Written protocols in place for any specific procedure undertaken with children and adults.

To include the following as a minimum:-

#### **Records**

The following to be delivered as a minimum:

- Record management policy, which ensures as a minimum adherence to Data protection Act, confidentiality and regular audit of records.
- Client information to be kept electronically
- Care plan completed with risk assessment where appropriate
- All visits/activity must be recorded in a legible, timely and accurate manner and shared with the CCG if required.
- Only one record to be kept per individual adult/child/young person. Where community working requires an accessible record, this should be filed with the notes when the patient is discharged and the notes should make reference to the additional record and where it is held
- Clear process for moving and tracking records to be in place
- Clear process of working towards the development of joint records

To include:

#### Health care plan.

- The patient's care plan is outcome based as identified from the holistic assessment and in accordance with the person centred plan (PCP) where appropriate with a minimum weekly review, but this can be a bi weekly review for level 1 package and monthly for level 2 and 3 if all parties, including the patient and their representative concur.
- The patient has an up to date plan of his/her care, which recognises the abilities, and responsibilities retained by him/her and their care's/parent(s)/guardian(s) and encourage him/her and carers/parent(s)/guardian(s) to share and supervise the care provision.
- The care plan has been fully developed and discussed with the patient and carer/parent(s)/guardian(s)/representative(s).

#### Risk assessment - minimum monthly review

- All assessments tools are in accordance with national guidance and evidence based practice and where available, a joint assessment tool has been used.
- The care plan and the assessment of need are made available to all involved in the care of the patient.

#### Daily written report on care

- The care plan is designed to enable flexibility of the service
- The care plan is reviewed at times of substantive and sustained change in care needs.
- The outcome of reviews and re-assessments are available, where the views of the patient and parent(s)/guardian(s)/representative(s) are recorded.

#### Medication administration record

Patients are protected by policies, procedures and protocols for dealing with medication and where appropriate are responsible for their own medication

The aim is to achieve concordance where there is shared decision making between parent(s)/guardian(s)/representative(s), the patient and healthcare professionals.

Regular reporting of information to be sent to the patient's case/ care manager as per case review documents.

#### **Initial Review**

Where a Patient is identified as requiring a Complex and Continuing Care Package, a Memorandum, of Agreement shall be completed in accordance with Service Schedule 3.1.1. following the full set up and start date of the care package. There will be an initial eligibility and care needs review after 3 months and then at least every 12 months unless there is substantive and sustained change.

The first 12 weeks of the Care Package for each Patient shall be regarded as a trial period in order to ensure that the care plan is satisfactory in meeting the needs of the Patient. The Provider is expected to demonstrate full flexibility and sensitivity, particularly during this period to ensure the delivery of care fits around the patient's personal life and relationships.

A Review will be held at the end of the twelve week trial period involving all parties to ensure that the patient remains eligible and their care needs are being met as well as consideration to any aspect of the Individual Care Plan or performance of the Services which may need revision. The Provider may combine this with their own internal review processes to ensure efficiency in reviewing care planning and delivery.

Where the care plan is confirmed with the agreement of all parties the care package shall continue as detailed in the Memorandum of Agreement.

Where the care plan is not confirmed as meeting the care needs, the NHS Authority shall make arrangements for a reassessment of need and provide a care plan and amended Memorandum of Agreement.

#### **Review/Variation**

Initially after the first three months and thereafter at least every twelve months, an appropriate Healthcare Funding eligibility review shall be carried out by the CCG. Where there is a significant and sustained change in a patient's care needs, The Provider must request a review by the NHS Authority immediately.

If the outcome of the review leads to a revision of the Care Plan the CGG will provide The Provider and Patient the following information within 14 days:

- A confirmation letter, incorporating an appropriate Healthcare Eligibility Assessment, setting out:
- The identified Authority that will pay The Provider for the provision of services to the Patient;
- The date upon which the process will commence; and
- Details of any further equipment or services which are to be provided to that Patient by the NHS Authority or The Provider.

The NHS Authority shall ensure that The Provider is notified in writing with the outcome of the Eligibility Assessment. For the avoidance of doubt, any changes in the Eligibility Assessment shall come into effect on the date of the of Eligibility Assessment or if the request for re-assessment of the Patient is other than the recommended 12 monthly Eligibility Assessment review, from the date of request.

If following completion of the Eligibility Assessment the patient is assessed as being entitled to a different level of care, a revised Referral and Funding Agreement will be submitted for authorisation by the CCG, prior to initiating any changes.

The terms of the Individual referral relating to each patient may be varied with the agreement of the NHS Authority and The Provider. Any such variation shall be confirmed by the NHS Authority giving updated information in respect of the Patient and or Services to be provided.

#### **TEMPORARY ABSENCES**

Hospitalisation.

Where the Patient is admitted to hospital, The Provider shall inform the CCG within 24 hours or 1 business day of the admission to the hospital; via telephone or e mail to the names case coordinator.

The Commissioner will continue to fund for the first four (4) hours of an admission to an alternative setting to facilitate the safe transition of the patient. The Provider will be advised as to the requirement for ongoing support/service need in the secondary care provider setting.

The Provider will identify if they are able to meet the needs of the change of circumstance on an individual case basis and arrange for an honorary contract agreement to be put in place with that acute trust. The CCG will not fund beyond the four hour timeframe as the healthcare responsibility for the patient once in hospital remains with the acute trust.

If The Provider's services are not required during the admission The Provider should contact the commissioning senior manager to agree the funding status and ongoing utilisation of staff.

#### **Critical Incident Monitoring**

All Adverse Events will be recorded, actioned and evaluated by The Provider's Nursing Co-ordinator. A report will be compiled and sent to the NHS Case Coordinator and be provided as a part of the review mechanism.

Critical Incidents that require immediate action will be communicated verbally as shown in the following table and then confirmed in writing within 24 hours or 1 working day.

Communication Matrix:

	THE PROVIDER	NHS AUTHORITY
During office hours	Patient's Nursing Co-ordinator	Designated day to day contact
Out of office hours	On call Nursing Co-ordinator	Designated day to day contact the following day.

## **DEATH OF PATIENT**

Upon the death of a Patient, The Provider shall be responsible for requesting the Patient's next of kin to make the necessary arrangements, including funeral arrangements, where required. This is the only involvement The Provider or CCG will have in this aspect.

The Provider must inform the NHS Authority within 24 hours or on the next business day of the death of a Patient via telephone or email.

Upon death of the patient, payment of the Total Fee shall be made in accordance with the notice period or reallocation of service.

### **3.2 Location(s) of service delivery**

Patient's home address up to 24 hours daily or other setting where appropriate to the agreed package of care. The Provider's main office can be located either inside or outside of the County of Dorset.

### **3.3 Days/hours of operation**

24 (twenty-four) hours per day/ 7 (seven) days per week/ 365 (three hundred and sixty five) days per year

The contractor shall ensure they are contactable by a staffed telephone line on Monday to Fridays between 08:00 and 17.00 hours. Outside of these hours it shall ensure that an answering service is operational to inform service users and of whom to contact. In case of emergency it will be expected that the service provider will have capacity to meet demand outside of specified hours.

## **Communication to clients**

### **3.4 Referral criteria and sources**

Any adult, child and young person living or registered to a General Practitioner within the County of Dorset who has complex health needs which fall within the agreed eligibility criteria.

### **3.5 Referral processes**

See Service delivery Section 3.1

### **3.7 Discharge processes**

See Service delivery Section 3.1

### **3.8 Response time and prioritisation**

See service delivery Section 3.1 -