

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	11J/0257
Service	<i>Domiciliary Care for Adults with Progressive Degenerative Conditions</i>
Commissioner Lead	<i>Personal Health Commissioning Dorset Clinical Commissioning Group</i>
Provider Lead	
Period	<i>1st April 2022 – 31st March 2032 (duration in line with the DCF2)</i>
Date of Review	<i>1st September annually</i>

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 by NHS Dorset Clinical Commissioning Group (Dorset CCG) for those individuals who are eligible for NHS Continuing Healthcare (CHC) and who are registered with a GP in Dorset. This service is to provide Domiciliary (Home) Care services for Adults diagnosed with a Progressive Degenerative Condition. In this Specification Domiciliary (Home) Care refers to care for people (the Individuals) living in their own homes, in some instances this may be a care home.

The Individual will require visits of agreed duration at various times of the day including Waking or Sleeping Night care 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. Due to the progressive nature of the conditions this service is designed to support, the care needs of the individual Individuals may increase at various rates necessitating an increased level of provision or assignment of more skilled carers, for example commencement with Health Care Assistant (HCA) support moving over time to Registered General Nurse (RGN) support.

Where there is good quality care, provided throughout the day, the Individual may live independently of any continuous support or care between the visits dependent upon the current state and prognosis of their condition.

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

- Individuals receive the care and support they need and have an enhanced quality of life;
- Supporting Individuals to feel empowered and involved in relation to the care they receive
- Individuals and their families/representatives have a positive experience of care and support;
- Individuals are helped to recover from episodes of ill health or following injury;
- Individuals are cared for in a safe environment and protected from avoidable harm;
- Individuals are treated to minimise pain, discomfort and anxiety, and other distressing symptoms whilst maximising quality of life;
- Health-related quality of life for Individuals with long-term conditions;
- Enhancing quality of life for Individuals with mental illness;
- Time spent in hospital by Individuals is minimised;
- Individuals feel supported to manage their condition;
- Individuals 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 Individuals who have been determined by the Commissioner as having an NHS-funded Continuing Healthcare (CHC) entitlement resulting from a primary diagnosis of a Progressive Degenerative Condition. This includes but is not limited to;

- Motor Neurone Disease (MND)
- Huntington's Disease
- Parkinson's Disease.

The Provider will ensure that the services can be provided every day of the year, 24 hours a day and in accordance with the Individual's Agreed Health Outcome Plan¹.

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. The service will provide reliable consistent care and support that enables individuals to increase choice and control over their daily lives, to achieve and maintain maximum possible independence and a sense of belonging. As part of this service, Staff are expected to look beyond the commissioned tasks and consider what assistance the Individual 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. Also, to contribute to the reduction of inappropriate hospital/hospice admissions where Individuals 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 Individual at the centre of care provision;
- Supports the Individual to make informed choices about their care, as per the NHS Constitution;

¹ Agreed Health Outcome Plan – a document setting out the Health needs of the Individual which the Provider, the content of which is agreed between the Commissioner and the Individual or their representative.

- 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 Individual;
- Provides continuity of care for the Individual, 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 Individuals and stay for the full time that is set out in the Individuals care plan;
- The Provider must be able to evidence Care Staff have undergone training required to possess the skills to meet their needs, including for Individuals receiving End of Life care;
- The care provided is carried out in a way that shows an understanding of and a concern for the Individuals and their support network.

The Provider shall adopt transparency and partnership working with all stakeholders and the Commissioner.

3.2 Service description/care pathway

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

Mobilisation of the package

The provider must mobilise within 10 working days once offered the package. During these 10 days an initial visit must be made and the CCG must have received copies of these assessments. Day 1 of the mobilisation period will be the next working day after the 10 day period.

The mobilisation period is the time it takes for the provider to provide a fully staffed rota for the package as required by the CCG.

3.3 Population Covered

Any Adult Individual registered with a Dorset GP.

3.4 Any acceptance and exclusion criteria.

All Individuals must be currently 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) to ensure seamless healthcare provision for the Individual.

4. Applicable Service Standards

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

Eligibility

The Commissioner will assess the appropriateness of the Individual's package, at 3 months (earlier than 3 months for Fast Track funded Individuals) and at least annually thereafter. Where there is clear evidence of a change in need, to the extent where it may impact on the Individual'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 e mail to continuingcare@dorsetccg.nhs.uk
- Provide appropriate representation to participate in the MDT process; this may not require full attendance at the MDT meeting
- Provide access to records and copies of any information in the format as required by the Commissioner, including information to facilitate review of care needs and care packages, in a timely manner.
- Liaise as required with the identified Professionals from the Commissioner's partner organisations.

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

Individual Needs

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

The Provider will develop their own Care Plan³ to meet the needs in consultation with the MDT, the Individual and any appropriately appointed Advocate. 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 Individual.

Strength and Assets Based Outcomes

The Provider's Care Plan will use the evidence-based recommendations from NICE to focus on identifying and supporting an individual Individual's strengths and assets:

- Through person-centred conversations, build a picture of the Individual's strengths, preferences, aspirations and needs.
- Provide any support needed to enable the Individual to express their views and participate in the conversations, including independent Advocacy if required. Such support to include the skills to aid the Individual is utilising appropriate Communication Aids.
- Involve the Individual's wider social network (carers, family, friends, Advocates) if that is their wish, and explore the support it may offer.

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

- Share information with the Individual in an accessible way so that they feel informed about care and support services, financial advice, safeguarding procedures, rights and entitlements, how to make a complaint, and personal budgets.
- Consider how to support and promote positive risk-taking.
- Promote the Individual's interests and independence, including through contingency and crisis planning, and their preferences for future care and treatment.

For further information see the link below:

<https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/evidence-for-strengths-and-asset-based-outcomes#personal-strengths>

Care Plans

The Provider must ensure the Care Plan is kept up to date. The Care Plan must contain the following sections:

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

Medical History – this must include (but is not limited to) the Individuals diagnosis and relevant medical history, including any allergies. It will record the Individuals medication and how it is administered (to include PRN protocols) and by whom, and full details of any specific training that 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 Individual's needs and the corresponding Provider requirements to meet those needs. It should state the Individuals preferences as informed by the "Individual 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 Individual, Carers and other persons associated with the care package. Examples of risks include: risks from the care environment, safeguarding risks, risks relating to Individual 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 by email to chc_commissioning@dorsetccg.nhs.uk. 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 Particulars 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 Individuals review.

In situations where urgent additional care is required for a rapidly deteriorating Individual 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 Individual's needs. Such situations include emergencies or sudden significant changes in the Individual's condition. The Provider has a responsibility to ensure such additional care provision be in reasonable proportion to the emergency need,

Care Package

The Provider will agree to deliver a care package in which every Individual 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. Should any concerns arise regarding the Individual these shall be escalated in line with the Provider's reporting procedures and mechanisms. Any Safeguarding concerns shall be raised in line with the Pan Dorset Safeguarding Policy per the website below:

<https://www.dorsetcouncil.gov.uk/care-and-support-for-adults/dorset-safeguarding-adults-board/dorset-safeguarding-adults-board.aspx>

Staff

The Provider will maximise Staff continuity to ensure the stability and sustainability of the service, and also to build trust within the package. The Provider will ensure all Staff are appropriately trained for the required tasks. The Provider will ensure all Staff are compliant with statutory and mandatory training requirements.

Staff will follow the Individual's Care Plan at all times.

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 Individual'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.

Staff will maintain professional boundaries and must not share their personal contact details (mobile phone/landline number, social media links or email address) with Individuals or their household/Next of Kin) without express written permission of the Provider.

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 Individual's home. Staff will be sensitive to that environment and its contents.

Staff will not:

- consume the Individual's food or drink without appropriate permission or invitation;
- use the Individual's possessions e.g., computer or telephone unless such use of the telephone is necessary to contact Emergency Services (Ambulance, Fire

Brigade, Police) in the event no other telephones such as Staff mobiles are able to do so.

- access the Individual's internet service (e.g., broadband, WIFI) without permission of the Individual or their appointed representative, such permission to be recorded in the Provider's records and available to the Commissioner
- use furniture or possessions in a way that the Individual would not want; and
- take responsibility for looking after any valuables on behalf of the Individual.

Any loss of or damage to the Individual's property should be immediately reported to the Individual. In the event that Staff are responsible for damage or loss the Provider will be responsible for compensating the Individual.

The Individual's possessions will only be disposed of with the permission of the Individual. Where the Individual's home compromises the ability to deliver safe and appropriate care the Provider will report this to the Commissioner.

Staff Training

The Provider will ensure staff complete training to support specific Progressive Degenerative Conditions such as Motor Neurone Disease (MND) appropriate to their required duties. Specific training requirements will be identified by the Commissioner and may include but not be limited to;

- NIV/ Cough Assist
- Suction
- PEG (Percutaneous Endoscopic Gastrostomy) feeding
- RIG (Radiologically Inserted Gastrostomy) feeding.
- Passive exercises as part of care
- Use of communication aids

Individuals Home

The Provider is responsible for ensuring a safe working environment for Staff and will operate an appropriate, up to date Lone Worker Policy which can be shared with the Commissioner on request. 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 Individual'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.

Individual 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 Individual.

All specialist equipment specified in the Agreed Health Outcome Plan will be supplied and funded by or via the Commissioner.

If the Individual 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 or the Commissioner's appointed maintenance/service provider 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 Individual 6 weeks and notify stock replenishment requirements to the Commissioner or

Commissioner's appointed stock replenishment supplier 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 Individual's home.

Where Fit Tested FFP3 respirator masks are required, the Provider will ensure all carers are correctly tested and utilise the masks for which they have been fitted.

Medication

The Provider will:

- seek information and advice from a qualified pharmacist regarding medicines policies (including the management of over-the-counter medicines and alternative medicines);
- liaise with GP surgery in relation to medications as required, including consideration of any covert medication protocol if necessary.
- liaise with the GP surgery and any Specialist Teams involved in the Individual's care where PEG/RIGs are required. Administration of medicines from blister packs or PRN medication for symptom management will be subject to the information and guidance of these professionals.
- store medicines correctly in the Individual's home and dispose of them safely
- not control Individuals' behaviour with inappropriate use of medicines,
- not give medicines prescribed for individual Individuals to any other person.

The Provider's medicines management policies will:

- include procedures for achieving the Individual's preferences and ensuring that the Individual'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> or most recent subsequent version

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 Individuals' 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:

Individual Guide – The provider will make the Individual Guide available and accessible to the Individual. 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, Individual 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 Individual 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 and correspondence with professionals;
- Any actions to be taken and the name of the person responsible; and
- The signatures and roles 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 and organisations specified by the Commissioner. Staff Training Logs will show the date training was completed, any relevant evidence, and the signature of the trainer (or other appropriate evidence) confirming that the training was completed satisfactorily. The Provider will complete the Staff Training Log and when requested share it with the Commissioner. Staff must be trained to deliver the support tasks required by the Care Plan, with the list of all appropriate training specified in the Staff Training Log.

Resuscitation and Medical Emergencies

The Provider is required to ensure that where the package of care identifies that the Individual may require resuscitation appropriately trained and qualified individuals will be provided. In all cases carers will have received at minimum Basic Life Support Training.

Interruption to Care – Provider

The Provider is responsible for informing the Commissioner when care has not been delivered due to the transfer of the Individual to another Service Provider within 24 hours of the aborted visit. The Provider must inform the Commissioner within 12 hours (or at

minimum the following morning if occurrence outside of office 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 Individual 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 or Hospice Stays

In the event that the Individual 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 Individual over to the hospital/hospice 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 Individual.

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

If the hospital/hospice requires the Provider's staff to support or provide care to the Individual while the Individual is in hospital/hospice this will be paid via Honorary Contract between the hospital and the Provider's staff and will not be paid by the Commissioner. The Provider is therefore required to identify the appropriate point of contact with the hospitals and hospices in the Dorset CCG area to enable such honorary contracts to be issued when needed without undue delay.

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 Individual, the Commissioner and the Provider.

The Provider or the Commissioner shall give not less than eight 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 Individual, or other Individuals, in which case the arrangement will be terminated as agreed between the Provider and Commissioner.

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	
Not Applicable	
7. Individual Placement	