Service Specification – CHC Approved Provider List – Homecare

1. Specification Area

Provision of social, personal and nursing care for adults, young people and children in their own home and/or other settings.

2. National/local context and evidence base

Trafford CCG are keen to work with providers to ensure sustainable, high quality homecare provision for all its population and welcome the opportunity to work with you to achieve this outcome. The work to develop quality Homecare provision is a mutual process and Trafford CCG is committed to supporting continuous improvement for patients.

The services are provided for adults and/or children and young people in the Trafford area with complex health needs who qualify for NHS Continuing healthcare (CHC) or children's continuing care funding. In 2015/16 the CCG received 546 applications for continuing healthcare and the projected total spend for homecare services 2016/17 to patients who are eligible for CHC is 1.9m.

Patients must be registered with a Trafford GP. For this service, 'NHS Continuing Healthcare or Children's Continuing Care' is a complete package of ongoing care for patients in their own home and outside their home arranged and funded by the NHS. The care can be provided over an extended period of time to meet assessed physical or mental health needs that have arisen as a result of disability, accident or illness.

This specification should be considered in context with the revised National Framework Guidance for Continuing Healthcare and the Trafford CCG Choice and Equity Policy.

2.1 NHS CHC Domains

- ✓ Preventing people from dying prematurely
- ✓ Enhancing quality of life for people with long term conditions
- ✓ Helping people to recover from episodes of ill health or following injury
- ✓ Ensuring people have a positive experience of care
- ✓ Treating and caring for people in safe environments and protecting them from avoidable harm.

2.2 Local Priorities

- ✓ Supporting patients to die in their place of choice
- ✓ Reducing Admission to hospital
- ✓ Safe and Timely discharge from hospital
- ✓ Meeting identified health outcomes
- ✓ Falls prevention

2.3 Locally agreed Outcomes

- The Patients abilities are maximised including cognitive, behavioural, physical, psychological, emotional, mobility and communicative capacity.
- The Patients health status and safety is optimised in regard to: skin integrity, concordance with medication, continence, infection prevention, nutrition and breathing.
- The Patient and/or representative feel involved in all aspects of their care planning.
- The Patient feels empowered to make decisions and choices about all aspects of their life, condition, care and services accessed.
- The Patient feels that they are at all times treated with dignity and respect.
- The Patient feels satisfied with the Services provided and believes that their quality of life is enhanced as a result or their representative where the Patient cannot comment.

The Provider will support the overall strategic aims of the CCG to ensure that the Trafford population has the best possible healthcare outcomes by commissioning high quality, equitable and integrated services.

Strategic aims:

- to improve population health;
- to improve the care provided and the healthcare experience of individuals; and
- to lower per capita costs of providing the above.

3. Patient acceptance and exclusion criteria

3.1 Acceptance criteria

Adults and/or children and young people in the Trafford GP or registered boundary area who qualify for NHS Continuing healthcare or children's continuing care funding. The Provider will deliver care for the following care categories in accordance with the registration status of the Provider with the Regulator, meeting relevant regulatory requirements and/or having appropriate accreditation being recognised by the Commissioner and the express and prior approval of the Commissioner:

- Older People
- Children
- End of Life;
- Learning Disability;
- Autistic Spectrum Disorder
- Mental Health;
- Dementia Care;
- Physical Disability; sensory impairment
- Long term condition; which would include motor neurone disease

- Challenging behaviour
- Muscular Dystrophy/Multiple Sclerosis

It must be noted that CHC eligibility is based on the presenting and primary health needs of the patient not their diagnosis.

All patients must be registered with a Trafford General Practitioner. Providers must be able to offer provision to all registered Trafford patients, across the Trafford Borough.

Individuals using the service will have been assessed in accordance with the NHS Continuing healthcare or children's continuing care process. Adults and children deemed acceptable for this funded service will have been assessed as having a primary health need, including a variety of physical, mental and learning disabilities. Funding for their respective care packages will have been considered and agreed by the Commissioner's Continuing Healthcare Panel, and approved by a senior CCG Manager.

Services commissioned will meet all the assessed needs of the patient and, where identified, be delivered in conjunction with Trafford community health services and relevant health professionals where the patient is registered within a boundary GP surgery.

3.2 Exclusion Criteria

This service does not apply to individuals who are presently living in NHS funded or self- funded residential and/or nursing care, nor individuals using social care sector contribution.

This service does not apply to individuals who require 24hr nursing care.

4. Service description and care pathway

The Provider must be registered with the Care Quality Commission (CQC) to provide personal care to individuals in receipt of NHS Continuing healthcare or children's continuing care funding who are no longer able to look after themselves in their own homes without support or whose families are unable to look after them in their homes. This may be due to a range of long-term physical or mental disabilities.

Hours of service delivery will be within a 24 hours per day, seven days per week, 52 weeks per year planned scheme according to assessed need.

Some Patients will only require support in their home setting for a short period of time until their condition has stabilised; once they have been assessed as being fit to live entirely independently, they will no longer require the services of the homecare agency.

Patients may require support in their home for a short or a long period of time but

may need to be transferred to a care facility (ie hospice/hospital/other nursing home) to receive specialist treatment, palliative or end of life care.

Due notification will be provided by the Commissioner (24 hours) of a discharge home from Hospice or Hospital for a package of care to re-commence.

It may be necessary for a Patient to be transferred to another homecare agency if the Provider is no longer able to meet the individual's needs due to deterioration in their health. Every effort will be made by the Provider to continue to meet the service user's changing needs and an alternative provider will only be sought once all other options have been explored

Referral for services will be in written format (secure e-mail) and circulated to Providers twice a day, at 9am and 12pm.

Implementation of service for patients at end of life (NHS CHC Framework Fast Track Patients) must begin within 24hrs of approval. All relevant documentation will be provided to the allocated Homecare provider.

Implementation of service for previously unknown patients, or known patients with significant change in need, being discharged from Hospital must begin within 48hrs of approval.

Implementation of service for known patients (restart) being discharged from hospital must begin with 24hrs of approval.

Implementation of long term care packages must begin within 72 hours of approval.

Wherever possible, Homecare Providers will be afforded the opportunity to assess the patient directly. This will be necessary where the patient is based in the community and the longer term planning of complex care is required.

Any delays to the implementation of the care package due to equipment approval or delivery must highlighted to the relevant Clinical Case Manager immediately.

Any delays to the implementation of the care package for a patient being discharged from hospital with medication or continence aids or other must be highlighted to the relevant Clinical Case Manager immediately.

The Homecare provider will be in receipt of written confirmation to commence or re-commence the package of care.

4.1 The CCG will ensure that;

- Care Plans are detailed to enable Providers to assess the needs of the person,
- Care Plans are clear in the need for specific support visit times during the day/night,

- Support times will detail 30 minute or 60 minute visits according to the assessed needs of the patient,
- Care Plans issued to providers will detail clear health outcomes,
- The Care Plan will indicate the level of support required (standard, enhanced or reg. nursing support),
- The Care Plan will detail the number of staff required for each care period/task,
- Where available, and appropriate, the Care Plan will be issued with the relevant Decision Support Tool documentation,
- The Training Brokerage Service, or similar model, will be offered to respond to the training needs of staff in order to improve the skills and knowledge of the services delivering services. Homecare agencies are required to ensure their staff are trained and competent to meet the needs of the patients they support.
- CHC process training is delivered twice a year.
- Unscheduled reviews are undertaken in a timely manner.

4.2 The following services must be provided:

- A safe environment for all patients and staff to meet the needs of the service user
- Risk Assessment regarding the environment and care delivery.
- Individualised care for all patients, respectfully meeting their identified needs and wishes, whilst maintaining their dignity and sense of wellbeing.
- High standards of person-centred care to patients in line with The National Framework for NHS Continuing healthcare or children's continuing care and NHS-funded Nursing Care.
- Adherence to, regular maintenance of and reviews of personalised care plans and risk assessments.
- Person-centred end of life care and palliative care where appropriate.
- Proactive monitoring of patients' health in order to reduce and prevent unplanned hospital admissions.
- Record keeping in line with quality requirements outlined at Schedule 4 Part C which reflect the standards set out in the Records Management: NHS Code of Practice.
- Provision of an effective complaints policy which is accessible to Patients.
- Compliance with staff training competence as detailed in the Care certificate and skills for care guidance. Additional training undertaken with reference to specific patient's needs may include LDQ, Six steps end of life care, mental capacity act, medication and or challenging behaviour support.
- Support to manage medicines in line with NICE guidance and quality standards including the use of homely remedies for and when required.
- Co-operation with the conducting of satisfaction surveys/service user audits to be undertaken on an ad hoc basis and implementation of the recommendations for change arising from the audit findings.
- Reference to, and compliance with, all related legislation and in accordance with meeting all Care Quality Commission regulations
- An on-going case management role, involving continual assessment and review of individuals' needs.

- Open, clear verbal and written communication with, and from, the relevant Commissioner regarding changing needs and risks.
- Achievement of patient care outcomes as detailed in the care plan.
- Every effort must be made to ensure that the staff employed by the Service Provider are based as near to the patient' homes as possible to enable visits to be arranged easily and to the times agreed with the Commissioner.
- Providers must be able to evidence that the visits are timely and completed for the duration agreed.
- Contingency plans must be drawn up to ensure service continuity during adverse weather conditions
- The Provider will not sub contract any commissioned services without the prior express consent of the Commissioner. For the avoidance of doubt the Provider may use Staffing Agencies to obtain staff, but these staff must have completed required training and induction prior to direct care implementation.

4.3 Specific Requirements

- Assessment
- Service start confirmation
- Support Planning
- Implementation
- Review
- Health Reviews and CHC reviews
- Direct support of Patients
- Liaison with relevant health and social care professionals
- Service end confirmation and/or notification of death

4.4 Safeguarding

- Providers will work with Trafford CCG and the Local Council to ensure that Patients are fully protected by the multi-agency safeguarding Policy.
- Providers will have an appropriate safeguarding policy, which is in compliance with the Local multi-agency policy, and can evidence staff training compliance. This Policy shall be available and current at the time of care package implementation.
- All staff working for the Provider will have a current Disclosure and Barring check.

4.5 Complaints and Termination of Care Agreements

Both the CCG and Homecare providers will communicate any formal complaints highlighted by the patient or family/rep within one week of receipt.
All complaints will be initially addressed by the Homecare provider.

Any dispute to the final Homecare provider complaint process will be mediated by the Clinical Case Manager.

In the case where disputes cannot be resolved the Homecare provider and the CCG will agree to **10 working days' notice** in order to provide the patient with a transferred new package of support. At all times communications and professional relationships with the patient will be positive.

In cases where the delivery of care to a patient is complex and a new provider will require training the Homecare provider and the CCG will agree to **25 working days**' **notice** in order to ensure patient safety and competence of new care delivery. At all times communications and professional relationships with the patient will be positive.

The CCG will highlight any patient reported, or observed, quality of service issues to the Homecare provider.

A record of quality compliments and/or concerns will be maintained by the CCG.

The CCG will develop a mutual quality monitoring system with Homecare providers.

4.6 Process for Care Package Allocation

- The CHC Approved List (Homecare) will maintain a list of providers who have been successful in the scoring matrix process and have received written confirmation of Approved Provider status,
- The CHC Approved List (Homecare) will detail the providers who are able to support specific groups of people and/or with specific presenting needs.
- Notification of anonymised care packages will be issued at 9am and 12pm.
- Anonymised care plans will be sent to those providers with the relevant specific service offer only initially.
- If quality provision is not allocated at this stage the anonymised care plan will be issued to all providers.
- Allocation of care will be based on the clinical quality screening process of the first response, should that response not meet the required quality clinical need the next received quality response will be considered.
- The package of care submission must detail the hours and approved provider rates specified.
- The allocated provider will be notified of the care package approval via secure e- mail.
- This notification will include all relevant and authorised contact details.
- The unsuccessful providers will be notified via secure email.
- The patient and/or family/representative will receive written confirmation, from the CCG, of their approved care package, which includes confirmation that any changes to the care package can only be approved by Trafford CCG.
- The care package will be detailed on the CCG finance and patient data system to correlate with the subsequent invoices submitted.
- Once approved the Homecare provider will contact the patient/family/representative directly.
- Approved Homecare providers will be issued with a 'change of circumstance' form. This form enables the provider to submit information regarding;

1. Confirmed service start date (notably in cases of hospital discharge)
2. Significant changes in need of the patient (with evidence attached)
3. Admission to respite care (and temporary cease of services)
4. Admission to hospital (and temporary cease of services)
5. Death of a patient (end of service from last shift on day of death)
6. Change of circumstances or address of a patient
7. End of service provision.

5. Case Management

- Homecare providers will attend CHC multi-disciplinary meetings/CHC review meetings and contribute evidence to the assessment/review process.
- Homecare providers will support the 3 month and annual review process as a minimum.
- Care package changes may only occur when the CCG has approved them in writing.
- In urgent circumstances i.e. where it can be evidenced that the patient or family is at risk, or rapid change in need is evidenced by a clinician, the Homecare provider must make every effort to provide suitable support.
- The Clinical Case Manager must be notified of, at the first available hour or working day, any urgent circumstantial, and temporary, change to the agreed care package.
- In the event that the Clinical Case Manager is unavailable the Homecare provider must contact the Duty Nurse.
- If, at the review stage, the patient/family/representative, indicates they wish to choose a personal health budget (PHB) option the Clinical Case Manager will notify the Homecare provider.
- Equally if the patient/family/representative notifies the Homecare provider of the decision for a PHB the Homecare provider must report this to the Duty Nurse.
- Please note the patient/representative has the right to be offered and considered for a PHB and this may result in the patient choosing another provider.
- Homecare providers must only converse with the relevant Clinical Case Manager regarding patient wellbeing, safety and health outcomes.

6. Standards and Duties

The Standards and Duties detailed in the section below forms the Quality Monitoring Framework and will be used to assess the delivery of services to patients in both a formal and ad hoc process.

6.1 Specific Staff Standards

- To provide safe physical and emotional care and support to maximise patients wellbeing
- Patients, their relatives and their representative are treated with courtesy at all times, patients are addressed by the name they prefer at all times
- To respect that care delivery is within a patient's own home and that conduct must reflect professional courtesy and boundaries
- That staff and their supervisors have a functional knowledge of the Mental Capacity Act and related principles.
- Patients, their relatives or representatives are consulted in advance whenever possible, and involved in the decision about the change of care or support worker, if the change is permanent or likely to last longer than 14 days.

- Patients, their relatives and/or representatives are kept fully informed on issues relating to their care, at all times.
- To provide care and support which meets the expectations of patients and the assessed needs identified by the Commissioner.
- To provide care and support which meets the social, cultural, religious and recreational needs of the patient.

6.2 Specific Staff Duties

The care plan will detail the needs of the patient and expected outcomes from the package of care commissioned.
Duties will vary according to the needs of the patients and may include the following for a **standard carer**;

- Personal care and support must be provided in a way which maintains and respects the privacy, dignity, safety and lifestyle of the person receiving care at all times with particular regard to assisting with:
  - dressing and undressing
  - bathing, washing, shaving, nail care and oral hygiene
  - skin care
  - toilet and continence requirements
  - support with medication requirements
  - manual handling and posture care
  - eating, drinking and meals
  - handling personal possessions and documents
  - entering the home, or moving from room to room
  - supporting effective communication with the patient
  - communicating effectively with all agencies involved
  - maximising optimum sleep patterns
  - managing behaviour which challenges/creates risk to self or others
  - assisting in social activities which maintain wellbeing
  - support to have contact with spouse, siblings and/or children

Some Patients will require support from staff who are more experienced and trained in regard to their specific condition/presenting needs. In addition to the duties above these **enhanced carers** could;

- Support the Patient with PEG site care, feeds and administration of prescribed medication as appropriately trained and supervised
- Support the patient with suction as appropriately trained and supervised
- Support Patient with artificial ventilation as appropriately trained and supervised
- Support with rescue medication as appropriately trained and supervised
- Work with specialist and district Nurses to manage pain relief and support end of life care
- Support Patient with complex bladder and bowel dysfunction for example stoma care
- Monitor safe and effective use of specialist equipment provided
- Support the Patient with skin integrity and pressure care

- maximize optimum nutritional and hydration status
- participate in the analysis, assessment and management of actual and potential risks to health and well-being.
- contribute to the multi-agency care planning approach for complex care support implementation of complex care
- to undertake tasks under the supervision of a Health Care professional

Nursing care will also be identified and required. These services can only be provided if the Provider is registered with the appropriate statutory body. In relation to children Nursing care must be carried out by a registered sick children's Nurse.