Herefordshire Council

NHS Herefordshire Clinical Commissioning Group

HEREFORDSHIRE COUNTY COUNCIL

SERVICE SPECIFICATION

FOR

THE PROVISION OF CARE FOR ADULTS

IN A CARE HOME WITH AND WITHOUT NURSING

CONTENTS

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1. OVERVIEW: AIMS OF SERVICE:

- **Delivering care that is person-centred, supporting a person's independence and whole well-being**
- **Delivering support that enables people to maintain personal choice about everyday life**
- **Delivering care that reflects safe, effective practice and maintains quality as a high priority**
- **Delivering care through well-maintained professional partnerships supported by good leadership**

2. INTRODUCTION

2.1 This document sets out the care specification and standards, which apply to the provision of care for adults in a care home with and without nursing ("the Service")

2.2 This document will be reviewed at regular intervals and information concerning any changes will be circulated to all providers on the framework.

2.3 Commissioners are committed to the development of a range of care services in which the Local Authority, Clinical Commissioning Group and independent providers work collaboratively in consultation, co-operation and partnership to ensure that appropriate services are available to meet the needs of adults living across Herefordshire.

2.4 Herefordshire has an ageing population which is greater than the national average and increasing. Therefore it is vital that the care home market provides flexible and responsive accommodation with a wrap-around package of care. It needs to offer a range and choice of quality assured residential and nursing support to both the elderly and working age adults with disabilities in the county. Hence, this Service needs to offer a range and choice of qualitative accredited residential support to both the elderly and working age adults with disabilities in the county. In order to enable people to maintain and or recover maximum independence, wellbeing and achieve the best outcomes for individuals; the Service must encompass the facility to meet both people's long term care needs whilst also providing sufficient support and care to meet their short term needs.

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3 LEGAL REQUIREMENTS AND CONTEXT

3.1 The Agreement places an obligation on the Provider to comply with all legislation and regulations which are relevant to the provision of the services.

3.2 This Specification reflects how the Provider supports the Commissioner in meeting the requirements of the Care Act 2014 for the care and support needs of people in a care home in order to ensure that the services:

- provide quality and choice
- are sustainable
- are flexible to incorporate any subsequent innovations within this market sector which will improve the Service and enable it to meet a diverse range of outcomes for people
- deliver a cost-effective service

3.3 Providers will be expected to demonstrate how service users' wellbeing can be assured whilst providing person-centred care and support. Providers are advised that for the purposes of this specification; wellbeing is defined in line with Care Act guidance as follows:

- personal dignity (including the way people are treated and helped)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control over day to day life (including making choices about the way care and support is provided)
- participation in work, education, training and recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society.

3.4 Continued collaboration between the Commissioners and Provider is imperative to ensure the success of the Agreement which will be designed in order to facilitate the development of services which perpetually meet the requisite outcomes to meet an individual's assessed needs.

3.5 The Provider must agree to adhere to the current West Midlands Multi-Agency Safeguarding Adults Policy and Procedures. A partnership approach will encourage proportionate responses and improve the involvement of service users themselves in the decision-making and involvement in prevention and developing resilience for themselves.

3.6 The Provider must be registered with the Care Quality Commission (CQC) in accordance with the Health and Social Care Act 2008 (as amended) and comply with all related requirements. The service offered to the Commissioner shall not exceed the "Type of Service" and "Specialism/Services" registered.

3.7 The Service must be delivered in accordance with the guidance provided by The National Social Care Institute of Excellence (SCIE) Think Local Act Personal (as amended) partnership for social care and health.

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3.8 In addition, the Service must be delivered in accordance with the guidance provided by The National Social Care Institute of Clinical Excellence (NICE) (as amended) in relation to clinical matters specifically for the Nursing and Midwifery Council Guidelines

3.9 Furthermore, the Service must be delivered in accordance with the guidance provided by; Public Health England, Resuscitation Council UK and the Royal Pharmaceutical Society Guidelines in relation to issues including but not limited to infection control.

3.10 From time to time, the Commissioners may seek the Provider's agreement to comply with any additional standards and recommendations issued by any relevant professional or by the National Institute for Health and Social Care Excellence (or any other equivalent body) in line with national policy and best practice within this sector of health and social care.

3.11 Whilst the Commissioners aim to refer Providers to good practice guidance, the Provider is expected to know and keep up to date with best practice. Providers are advised that details of the current legislation which is applicable to this Service is available on the CQC website which can be accessed via the following link: http://www.cqc.org.uk

4. Outcome Based Commissioning

4.1 The Government has in recent years issued guidance instructing councils and NHS providers to give people using care services more choice and control over how and when their needs are met. The recent paper 'Commissioning For Better Outcomes: A Route Map' sets out the purpose and standards on what is good commissioning for person-centred services and focusses on outcomes, good commissioning being well led, and promotes a sustainable and diverse market.

4.2 The introduction of self-directed support, personal budgets and direct payments has instigated the provision of choice and control for individual service users which offers a platform for individuals to express a preference in relation to their desired features of the Services which they receive. However, this has resulted in a significant change to the way social care is commissioned. Instead of local authorities contracting for services with independent providers, there is now a shift away from this traditional contracting relationship to one that exists between the service user and the provider. The role of local authorities is now largely one that develops the market to ensure service users are able to purchase services of their choice and provides information, guidance and advice to service users to assist them in making informed choices.

4.3 There will, however, continue to be a need to contract some services on behalf of service users who are not able or do not wish to 'manage' their own care and support. The contracting that is being developed for the

foreseeable future is moving away from the traditional time and task based services to services which are designed and delivered to achieve agreed outcomes. This in turn impacts upon the way providers operate and how contracts are reviewed and monitored.

4.4 The Commissioners are aiming to advance outcome based commissioning in Herefordshire and this new approach to commissioning will be progressively delivered during the course of this Contract. This will be dependent upon a trusted working relationship between the Service User, the Provider and the Commissioners. It is currently envisaged that during the first year of the Contract, the Service User Support Plans will reflect the traditional time and task based processes but increasingly will allow for a more flexible approach.

4.5 The aim of an outcome based approach is to shift the focus from activities to results and from activities and processes to the impacts of these on service users. Success in achievement of individual outcomes will be evidenced primarily but not exclusively by changes in behaviour, condition and satisfaction levels of Service Users and their carers ensuring services are designed around the individual needs of Service Users.

4.6 Achievement of the individual outcomes identified in the Service User's Support Plan shall ensure that Service Users:

4.6.1 are valued – involved, more in control, listened to, told what is happening, given choices, at the centre of what is happening to them;

4.6.2 retain their independence – ensuring that an individual's quality of life is maintained by keeping active and alert, maintaining mobility/physical *health, maintaining hygiene, maintaining social contact and keeping safe and secure;*

4.6.3 are supported through change, e.g. post-operatively, at the end of their lives, and in situations where poor care or self-care has resulted in a reduction in their independence; and

4.6.4 are safe – services are well managed and provided by staff who are appropriately trained and who understand about person centred approaches and how to work with Service Users to achieve outcomes.

4.7 The Provider will use a support planning process that:

4.7.1 is person centred;

4.7.2 identifies and reviews achievement of individual outcomes for Service Users;

4.7.3 provides clarity for Service Users about what they should expect from the service;

4.7.4 provides clarity for care staff about what support they should provide and how they should provide it;

4.7.5 sets clear goals for the individual; and evidences clear and achievable outcomes that promote independence.

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5. THE SERVICE

5.1 Eligibility

The service will relate to any adult placements aged 18 and above whose assessed needs have been identified as being met in a care home with or without nursing.

5.2 The provider will be expected to complete their own assessment to ensure they can meet the service user needs now and in the future.

5.3 Services provided need to meet the essential care requirements which may be identified in the Service User's Support Plan but also need to be flexible to fit in with the lifestyles of Service Users. Service provision must be able to take account of any changes to a Service User's routine, and also short term changes in health. It is recognised however, that the provision of truly flexible services may prove difficult within the constraints of available funding, staff rotas and call times. Consequently Providers will be creative when considering how they configure services to maximise their capacity to be flexible.

5.4 Service provision shall enable Service Users to make more informed choices about what they do and how they do it. The Provider must have arrangements in place that can identify and manage this appropriately.

5.5 Level of need

Service Users will have a diverse range of needs including those with mild and moderate needs, people with complex needs, challenging behaviour, mobility needs and disabilities and sensory impairment (including acquired brain injury).

Care home services must be staffed 24 hours a day, 7 days a week, every week of the year by appropriately trained staff.

5.6 Referral arrangements

Service Users will be referred by the Commissioner. Full written information relating to individual assessed needs for each Service User will be provided and this will include outcomes required for each Service User and any additional special requirements.

5.7 Core service

In line with the requirements of this service specification, the Provider is expected to deliver the core elements of care. The Service User's package may include all or some of these core elements. However, there is an expectation that the service will meet all the needs identified in the core service.

5.8 Support Plans:

The Provider will adopt and implement Support Plans in respect of each Service User based on the assessment carried out by the Adult Social Care Assessment Team, their own pre-admission information and the wishes of the service user and where appropriate the Service User's family/carer/advocate.

5.9 Personal Care:

Personal Care services are services that attend to the physical needs of Service Users. Service Users will be helped and/or prompted with intimate physical care and treatment sensitively, discretely and in a way that maintains their dignity and privacy and in line with the Service User's Support Plan.

5.10 Domestic Services:

Domestic Care services are those that enable a Service User to maintain their living environment including laundry provision. The Provider will retain overall responsibility in ensuring that the Service User's living environment is maintained to a high standard. Where Service Users indicate a wish to get involved then the Provider should where appropriate and safe make provision which enables this to happen. This could include doing, assisting, supporting and encouraging an individual with: light meal preparation, maintaining the cleanliness of living space, general tidying, ironing and laundry.

5.11 Social and Recreational Activities

The Provider is required to plan, deliver and facilitate positive and person centred activities and experiences that are focused on providing a purposeful day. The aim should be to ensure that the activity or experience meets the individual needs, wishes and preferences of the Service User. In some instances this may require accompanying the Service User to access activities.

5.12 Community Support Services:

Community support services are those that enable a Service User to access their local community and are supported to maintaining a relationship with community based services. These services could include assisting, advising, supporting, accompanying and encouraging a Service User with access to:

- Community activities (such as libraries, places of worship)
- Social networks, maintain relationships including family.
- Enabling opportunities to education and employment (this could be paid or voluntary work).
- Supporting Service Users to manage their finances.

5.13 Respite Care

The Provider will be expected to develop Care Plans based on the principles outlined in this specification for Service Users, who are accessing services on a short term or respite basis. On leaving the service, the Provider will ensure that information is made available to the family/carer/advocate regarding the service user's stay.

5.14 Equipment

The purpose of providing equipment is to increase or maintain functional independence and well-being of Service Users as part of a risk management process. Whilst is it expected that care homes will provide the majority of equipment please refer to the Equipment in Care Homes policy for further information.

5.15 Meals/nutrition:

The Provider shall supply three meals a day along with drinks and snacks that will be available and accessible throughout the day and night. The Provider is required to provide a choice of food and drink that reflects the service user's personal preferences, and dietary requirements.

The Provider will be required to support Service Users to eat and drink as independently as possible in line with what is recorded in their Support Plan. The Provider will ensure that meals and meal times are flexible which meet the preferences of the service user.

The Provider will ensure that Service Users are supported to eat and drink in a way that promotes dignity.

5.16 Continence

The Provider will provide effective bladder and bowel management for all Service Users, including for incontinence and constipation. Referrals should be made to the specialist services where appropriate.

5.17 Tissue Viability

The Provider is responsible for risk assessment, prevention and management of pressure areas. Referrals should be made to the specialist services where appropriate.

5.18 Infection Control

Meet the requirements detailed in the CQC Health and Social Care Act (2008) (as amended).

Ensure all policies and procedures relating to Infection Prevention and Control are written with regard to current NICE guidelines and that this is referenced within the home's policies and procedures. Ensure the care home has the policies and procedures listed as requested within the Health and Social Care Act (2008) (as amended).

5.19 Pressure Care

The Provider will:

Ensure that all policies and procedures have regard to current NICE guidelines regarding tissue viability, in particular NICE clinical guideline (as amended)

Ensure all staff are aware of their role in maintaining healthy skin, pressure ulcer prevention and management;

5.20 Transport and Travel

The Provider is required to make arrangements to meet the transport and travel requirements of Service Users, and to promote person-centred solutions to transport which maximise independence, choice and control. A variety of transport and travel methods should be considered by the Provider in seeking to make suitable arrangements to meet the transport and travel needs of each service user using the Service. The Provider will need to ensure transport organised is safe and suitable in meeting a service user's individual needs. Risk assessments should be carried out where appropriate.

5.21 Mental Capacity Act and Deprivation of Liberty Safeguards

The Provider shall work within the principles of the Mental Capacity Act (2005) (MCA) (as amended) and the corresponding Code of Practice to understand best practice and in particular best interests decision making in regard to that legislation.

The provider will be expected to understand their responsibility under the Deprivation of Liberties Safeguards (DOLS) addendum to MCA and the Deprivation of Liberty Safeguards Code of Practice.

5.22 End of Life Services:

The Provider will facilitate early discussion about preferences at the end of life.

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The Provider will offer an Advance Care Plan to all Service Users within three months of admission, using a recognised care planning tool. Advance Care Plans should be reviewed upon any significant change in the Service User's condition and at least annually.

The Provider will have formal processes for appropriate onward referral to Primary Care or District Nursing Services when appropriate. Following the identification of significant changes or deterioration in the Service User's health condition it may be appropriate to review the increased care needs of the Service User and consider the continued appropriateness of the placement.

The Provider must have processes in place to identify and address the training needs of all staff (including registered nurses) with regard to end of life care, including communication skills, assessment care planning, and advanced care planning and symptom management.

The Provider will ensure referral to specialist palliative care services where required to ensure service users receive effective palliative care symptom management at end of life.

5.23 Whistle Blowing

The Provider must have a whistle blowing procedure in accordance with the Public Interest Disclosure Act 1998 (as amended).

5.24 Interdependence with other services/providers

Contact with other services will vary according to the identified needs of individual service users. The provider will co-ordinate and ensure communication between such relevant services. The service shall be integrated into relevant pathways (e.g. end of life) as may be adopted by HCCG.

- The Provider shall ensure that Service Users have access to a full range of primary health care services for example: GP, Dentistry, Podiatry, Optician, Chiropody etc.
- The Provider shall ensure that Service User referrals are made in a timely manner and are followed up when a referral is not accepted or actioned.
- The Provider shall advise the Commissioners at any point that it appears that a Service User may require an advocacy service or an Independent Mental Capacity Advocate and shall provide all reasonable assistance and cooperation to the advocacy service / Independent Mental Capacity Advocate appointed in respect of any Service User including access to all information held in regard of that Service User and access to the service user at all times

- The Services should be seen as part of wider integrated adult health and social care services working in partnership with gps, primary health care teams, acute providers, local authorities, community mental health teams, the voluntary & community sector and independent providers.

- The Provider must demonstrate how it will work with these other organisations to support Service Users and their Carers to successfully manage Service Users' conditions. They should as a minimum have a well-developed and audited pathway for communication with GPs and the wider health, voluntary and social services environment.

- In addition to the statutory requirement to report all safeguarding issues to CQC and

the relevant local authority, all safeguarding issues should be reported to Commissioners at the same time.

5.25 Service Development

The Provider will be required to collect and analyse information on outcomes for the individual Service Users in order to inform understanding of best practice and service development. It is recognised that this is change to the current contract and therefore this will be developed over the first year of the contract with both providers and commissioners.

The Provider shall be willing to share and actively disseminate best practice and information on needs and outcomes.

It is expected that wherever possible and or appropriate, the Provider consider the use of assisted technology.

6.0 Contract monitoring/reporting

The Commissioners will use the Quality Assurance Framework to monitor the effectiveness and quality of the residential care services provided, ensuring the outcomes identified are met. This will include monthly returns and a self-assessment to be complete on an annual basis.

It will be a requirement of the contract for Providers to work in conjunction with Commissioners to develop outcome based commissioning with service users and ensure that the outcomes specific to individuals are recorded, reported and met. A suite of indicators will be developed in line with quality standards and subject to the same monitoring process as identified within the quality assurance process.

It is expected that the Provider shall regularly meet with the Commissioner from time to time to discuss any element relating to the contract and future service development.

It is expected that the Provider will inform the Commissioner within two working days of any changes to the management role which includes but not limited to notice being given or if applicable suspension.

It will be the responsibility of the Provider to ensure that the Commissioner is kept informed on current contact details to ensure communications relevant to the contract can be communicated effectively and in a timely manner.

6.1 It is expected that nursing care homes work to the below NHS outcome framework domains and indicators and the locally defined outcomes.

6.2 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**	√

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