Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2223/013

Subject: Mental Health, Learning Disabilities and Autism Commissioning

*I can confirm that the ICB **does hold some of the information requested**; please see responses below:*

QUESTION	RESPONSE
Please refer to requesters template enclosed	

The information provided in this response is accurate as of 3 August 2022 and has been approved for release by Rosi Shepherd, Director of Nursing and Quality for NHS Bristol, North Somerset and South Gloucestershire ICB.

Dear Colleague

I am making this request for the sharing of information you hold under the Freedom of Information Act 2000. The information requested relates to the commissioning and provision of Mental Health Learning Disabilities and Autism clients. Can you please provide the following information?

1. Commissioning & Contracting

Clarification:

- **Transforming Care – LDA? Does this refer to the individuals who are in inpatient settings only – Yes please only hospital inpatients**
- **Responsible commissioner – Patients who have been placed in your area by another placing authority.**

1.1 In relation to the following client groups, are you the sole commissioner?		
Transforming Care - LDA	Yes ☐	No ☒
Learning Disabilities (CHC only)	Yes ☒	No ☐
Responsible Commissioner	Yes ☐	No ☒
Mental Health (CHC and S3 secure detained)	Yes ☐	No ☒
S117	Yes ☐	No ☒

***For LD and MH these will be your ICB area clients whereas responsible commissioner clients are those placed into your area by another local authority to which you are funding under the Who Pays guidance.**

1.1.1. For Transforming Care – LDA - please tick the relevant box	
Spot Purchase only (no service specification)	☐
Spot Purchase only (service specification and contract in place)	☐
Framework contract agreement with the LA (LA lead commissioner)	☐
Framework contract agreement with the LA (ICB lead commissioner)	☐
Prime provider model – ICB lead commissioner	☐
Prime provider model – LA lead commissioner	☐
A mixture of Framework and Spot purchase	☒
Other (please elaborate) … For the individuals in independent inpatient (rehabilitation) settings the ICB uses a spot purchase method. For individuals in secure settings this care is commissioned by NHSE under framework.	☒

1.1.2. For Learning Disabilities - please tick the relevant box (Answer refers to CHC funded LD cases only)	
Spot Purchase only (no service specification)	☐

Spot Purchase only (service specification and contract in place)	☒
Framework contract agreement with the LA (LA lead commissioner)	☐
Framework contract agreement with the LA (ICB lead commissioner)	☐
Prime provider model – ICB lead commissioner	☐
Prime provider model – LA lead commissioner	☐
A mixture of Framework and Spot purchase	☐
Other (please elaborate) …	☐

1.1.3. For Responsible Commissioner - please tick the relevant box	
Spot Purchase only (no service specification)	☐
Spot Purchase only (service specification and contract in place)	☐
Framework contract agreement with the LA (LA lead commissioner)	☒
Framework contract agreement with the LA (ICB lead commissioner)	☒
Prime provider model – ICB lead commissioner	☐
Prime provider model – LA lead commissioner	☐
A mixture of Framework and Spot purchase	☐
Other (please elaborate) …	☐

1.1.4. For Mental Health - please tick the relevant box	
Spot Purchase only (no service specification)	☐
Spot Purchase only (service specification and contract in place)	☐
Framework contract agreement with the LA (LA lead commissioner)	☐
Framework contract agreement with the LA (ICB lead commissioner)	☐
Prime provider model – ICB lead commissioner	☐
Prime provider model – LA lead commissioner	☐
A mixture of Framework and Spot purchase	☒
Other (please elaborate) … For the individuals in independent inpatient (rehabilitation) settings the ICB uses a spot purchase process. For individuals in secure settings this care is commissioned by NHSE. Individuals in ICB inpatient settings there is a spot purchase contract in place. For individuals in receipt of CHC placements are spot purchased with a service specification and contract in place.	☐

1.1.5. For S117 - please tick the relevant box	
Spot Purchase only (no service specification)	☐
Spot Purchase only (service specification and contract in place)	☐
Framework contract agreement with the LA (LA lead commissioner)	☒

Framework contract agreement with the LA (ICB lead commissioner)	☐
Prime provider model – ICB lead commissioner	☐
Prime provider model – LA lead commissioner	☐
A mixture of Framework and Spot purchase	☐
Other (please elaborate) …	☐

1.2. Would you be happy to share your specification if you have one in place	
Yes ☒ No ☐ **Do not have a specification ☐**	**Please embed here:**  2022-24 CHC Care Home Spec.docx  2022-24 CHC Dom Care Spec.docx

1.3. If not the sole commissioner, what are your commissioning arrangements, i.e. joint with local authorities, provider trusts etc.	
Transforming Care – LDA	NHS England
Learning Disabilities	N/A
Responsible Commissioner	BNSSG ICB has no cases meeting the definition outlined at the outset of this FOI.
Mental Health	CHC – N/A NHS England – secure placements
S117	Via Section 75 arrangements with BNSSG Local Authorities

2. Client Numbers

As at 31st March 2022, what were your client numbers for each of the following client groups:	
Transforming Care – LDA	16 individuals in secure settings
Learning Disabilities	96 CHC funded individuals
Responsible Commissioner	0
Mental Health	42 CHC funded individuals
S117	Bristol – BNSSG ICB does not hold this data.

	N. Somerset – 300 S. Glos – 80

3. Pricing

3.1. Can you please provide information on the pricing structure for each of the following client groups?			
Service	**Lowest Weekly fee**	**Average Weekly fee**	**Highest Weekly fee**
Transforming Care - LDA	£1,522	£3,301	£5,514
Learning Disabilities (CHC)	£260	£3,792	£27,037
Responsible Commissioner	N/A	N/A	N/A
Mental Health (CHC)	£451	£1,333	£3,238
S117 (ICB's contribution to the S117 package)	£23	£501	£3,411

3.2. Please state the set hourly rate for additional one to one support		
Service	**Lowest Hourly rate**	**Highest Hourly rate**
Transforming Care - LDA	See "Other" below	
Learning Disabilities	See "Other" below	
Responsible Commissioner	See "Other" below	
Mental Health	See "Other" below	
S117	The ICB does not hold this information	The ICB does not hold this information
Other – These rates are applicable to all CCG commissioned placement types listed above and are defined as standard weekday rates	£16.88	£31.85

3.3. If you operate a tiered pricing model on a framework can you please provide details	
Transforming Care – LDA	N/A
Learning Disabilities	N/A
Responsible Commissioner	N/A
Mental Health	N/A
S117	N/A

4. Brokerage

4.1 In relation to the following services, do you have a brokerage function?		
Transforming Care - LDA	Yes ☒	No ☐
Learning Disabilities	Yes ☒	No ☐
Responsible Commissioner	Yes ☐	No ☐
Mental Health	Yes ☒	No ☐
S117	Yes ☒	No ☐

5. Other

5.1 Please add anything else which you feel has a profound effect on the commissioning of placements and the impact on pricing?

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service name
NHS BNSSG ICB Home Care Specification 2022-2024

Service specification number
02 - 2022

Population and/or geography to be served
This Specification relates to Service Providers operating within the BNSSG boundaries. On occasion services may be commissioned for service users living outside of these boundaries. All service users will be registered with a BNSSG General Practitioner at the point of CHC eligibility determination

1. Introduction

This document is the Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) specification for Home Care services. It relates to all Service User groups where BNSSG ICB is responsible for full funding of the package of care.

1.1 Core Principles

The overarching core principles for the provision of Home Care services that underpin the expected delivery of care are as follows:

Providers of Home Care services will:

i) Promote high quality of life for Service Users as paramount.
ii) Recognise that Service Users are individuals, and not defined by their health condition or disability.
iii) Recognise and uphold the diversity, values and human rights of people using the service.
iv) Uphold Service Users' privacy, dignity and independence.
v) Provide information that supports Service Users and their support network, to understand the care, treatment and support and to make decisions about it.
vi) Enable Service Users to care for themselves where possible, maximising their independence, working with a reablement approach wherever possible.
vii) Encourage Service Users and their support network to be involved in how the home is run and to ensure the service feels homely.
viii) Ensure that the views and wishes of Service Users are paramount in the delivery of their care.

1.2 Quality Assurance and Monitoring

BNSSG ICB requires the provider where applicable to be registered with the Care Quality Commission (CQC) and that standards never fall below their Fundamental Standard Regulations.

Providers will be required to take responsibility for the quality and quality assurance of all aspects of their services.

BNSSG ICB's relationship with the provider is separate to the role of the regulator (CQC).

BNSSG ICB's responsibility is for monitoring how the Provider is performing under the NHS contract. BNSSG ICB will check that Providers deliver high quality care and support to all service users for all their services by means of quality assurance visits. These may be unannounced.

1.3 NHS email system

The Provider will ensure that they can receive emails from the Commissioner and send electronic communications to the Commissioner using an encrypted email system.

NHS England are supporting the enablement of secure email accounts for Home Care providers to safely exchange patient or sensitive information with other health and social care professionals via NHSmail. To join NHSmail via the national administration registration process please use the online registration portal tool here:

https://portal.nhs.net/Registration#/careprovider

The Provider will ensure there are always sufficient staff that are suitably trained and available to access and acknowledge receipt of all secure emails within one operational day of the email being sent by the Commissioner.

Providers will have arrangements in place to rapidly respond to invitations to provide service for those individuals at end of life.

The Commissioner will expect the Service Provider to have at least one NHSmail address in use to share secure information.

2. Outcomes

2.1 NHS Outcomes Framework Domains and 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**	✓

Where appropriate as agreed with commissioners the Service Provider will report on individual care and progress or significant changes in packages of care.

2.2 Local Defined Outcomes

Domain 1: Preventing people from dying prematurely

- ✓ Dying with dignity/better coordinated and planned end of life care
- ✓ Reducing premature death in people with serious mental illness and/or a learning disability
- ✓ Ensuring Service Users are regularly reviewed and any developing problems are treated as soon as possible.

Domain 2: Enhancing quality of life for people with long-term conditions

- ✓ Proactive approach to care and treatment
- ✓ Care is delivered with re-ablement as the core outcome.
- ✓ Prevention of hospital attendances and admissions related to long term conditions, mental illness or poor nutrition

Domain 3: Helping people to recover from episodes of ill-health or following injury

- ✓ Effective discharge management and prevention of readmission

Domain 4: Ensuring people have a positive experience of care

- ✓ Service Users will have agreed person centred care plans detailing specific outcomes for each individual.
- ✓ Service Users will be offered the opportunity to partake in activities of interest to them.
- ✓ Service Users' care will be delivered in a culturally appropriate manner taking their lifestyle choices into consideration.

Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm

- ✓ Preventing avoidable and non-elective hospital attendances and admissions
- ✓ Better use of primary care/GP practice resources
- ✓ Effective, timely, evidence-based and appropriate use of medicines and nutritional supplements
- ✓ A stable and appropriately trained workforce
- ✓ Appropriate use of extra resources (i.e. 1:1) to ensure the safety of Service Users.
- ✓ Service Users and relatives feel safe and protected by the Service Provider and know how they can raise a concern or complaint as to how care is being delivered.

2.3 Service Specific Outcomes

Service Specific Outcomes	
Safe	<u>Service Users are Safe</u> The Provider will protect Service Users from fear, abuse and neglect by ensuring staff are aware of their duties relating to Safeguarding under the Care Act 2015 and receive comprehensive training on the awareness and prevention of abuse. The Provider will have in place a clear process and associated documentation for recording allegations of abuse. The Provider will ensure that the CQC, if applicable, and BNSSG ICB are informed of all safeguarding concerns.
Safe	<u>Mental Capacity Act & Deprivation of Liberty Safeguards</u> Providers will support Service Users as much as possible to make their own decisions; anything done for or on behalf of people without capacity is the least restrictive to their basic human rights and done in their best interests. The provider will have in place a clear procedure that sets out the actions required of staff in relation to Service Users who do not have the capacity to make decisions and will ensure that all staff are trained and able to demonstrate knowledge and practice of the Mental Capacity Act and Deprivation of Liberty Safeguards. Assessments of capacity and best interest decisions (Mental Capacity Act) will be reviewed by the provider on at least a monthly basis.

Safe	Reviews The provider will undertake regular reviews of Care and Support Plans that involve the Service User, the Commissioner and the Service User's support networks to ensure that the Service User's needs as required by the care provision continue to be met. To demonstrate that the outcomes of the care provision are being met, the provider may be required to respond to information requests in relation to the Service Users Care & Support plan that are made by BNSSG ICB The provider will comply with individual case reviews undertaken by ICB appointed staff.
Caring	End of Life Care The Provider will work within NICE's guidelines for end of life care to ensure that the physical, emotional and spiritual needs of Service Users are met and that they live out their lives in as dignified and peaceful a manner of their choosing. https://www.nice.org.uk/guidance/qs144 Care delivery will be managed in accordance with "One Chance to get it Right" https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-progress. Where possible, Services Users are involved in the assessment and planning of their End of Life Care. To meet the Service Users wishes in the event of death, an Advance Person-centred care plan should be in place that is linked to the GP notes and is clearly documented in the Service Users Care & Support Plan.
Caring	Person Centered Care The service promotes and embeds person-centered care as standard practice in care planning and delivery so that Service Users are treated as individuals with unique backgrounds, qualities, abilities, interests, preferences and needs. The Service User will be allocated a key worker who understands their individual needs and preferences and regularly liaises with the Service User's support network.
Responsive	Dignity & Respect The Provider will actively promote dignity, respect and independence ensuring that Service Users have a Care and Support plan that refers to their personal wishes, preferences and priorities and to the support they need in order to retain their dignity and develop their sense of personal identity.
Responsive	Equalities The Provider must ensure that Service Users do not experience direct or indirect discrimination, harassment or prejudice arising from their age, disability, race, sex, gender reassignment (transgender), sexual orientation, marriage and civil partnership, pregnancy and maternity and religion and belief (including those with no religion and belief) in the way services are provided or in the way they are treated by staff, other Service Users, visitors, family and friends.
Responsive	Choice, Control & Engagement The Provider will promote Service User choice and control. Service Users will be in control of their own life and if possible, will be encouraged to live independently in the community with an appropriate support provider if they so wish. The Service User will be consulted as to what their needs, wishes and preferences are in all aspects of their life, including participation in activities in the community and these will be recorded in the Service users Care & Support Plan.

Effective	Quality Assurance The Provider will facilitate unannounced quality assurance visits from BNSSG ICB. BNSSG ICB will issue a report to the Provider within 12 working days of the completion of the visit unless otherwise indicated, comprehensive verbal feedback will be given on the day at the end of the visit. The Provider ensures that where BNSSG ICB or CQC, if applicable, have issued compliance actions or recommendations for service improvement, these are incorporated within a service improvement plan and action taken as per the timescales agreed with the BNSSG ICB / CQC. This may include an improvement plan arising from the safeguarding process in Bristol and/or another relevant local authority. The service improvement plan will be shared with BNSSG ICB.
Effective	Management of Health & Wellbeing? The Provider will ensure that unnecessary admissions to hospital are avoided through proactive management and review of Service Users' health and wellbeing needs including: ▪ Screening for risk of malnutrition using a validated tool such as MUST. Providers must ensure that service users have access to a wide range of food and drinks and that food and drink intake is monitored and recorded for those identified as malnourished or at risk of malnutrition. ▪ Staff are trained to recognise the verbal and physical signs of pain. The provider must ensure that any change in health status or behaviour is recorded and that evidence is maintained of health appointments / referrals for specialist advice. ▪ Assessment of foot care needs of the Service User by an appropriately trained health professional is made within 4 weeks of admission and recorded in the Care and Support plan. ▪ Maintenance of oral comfort and hygiene of Service Users ▪ Assessment of tissue viability is undertaken on service commencement. Pressure areas must be reviewed regularly using the SSKIN Care bundle and pressure relieving equipment is provided as appropriate. All Category 3 and 4 wounds must be referred to the NHS tissue viability service and reported to the CQC, if applicable. ▪ A falls risk assessment is completed within 24 hours of the Service User's admission and the outcome recorded in the Care and Support Plan. Those Service Users who are vulnerable to falls are actively supported by their key worker or equivalent member of care / nursing staff to reduce / prevent the risk of a fall occurring and thereby supporting a reduction in unnecessary emergency admissions related to falls. The provider will maintain a register of falls, undertaking audits to ensure that necessary actions are taken to reduce falls and avoid unnecessary admissions to hospital ▪ The Provider will ensure that prescription-only medicines are administered in accordance with a valid prescription. All administration errors are recorded as a clinical incident and reported to CQC, if applicable, and advice is sought from the GP or pharmacist. The Provider will ensure that any decision to covertly administer medication is documented in the Service Users' Care and Support Plan, including information on: - Decision specific Mental Capacity Assessment. - Best Interest decision and reason for convert administration of medication. - That the suitability of administering the medicines with food and drink has been checked with a pharmacist. - Whether the Service User is likely to recover so as to be capable of making their own treatment decisions in the near future. - The Provider will ensure regular reviews are undertaken to assess the continued appropriateness of covert administration where this occurs.

Effective	Mental Well Being The Provider will maintain an environment that promotes mental wellbeing and provides opportunities for Service Users to meet their mental health needs as appropriate. Working with other relevant services, the Provider will ensure that Service Users' mental health needs are met and that Service Users are able to maintain an acceptable level of mental wellbeing.
Effective	Complaints The Provider will have a process in place that ensures that all concerns and complaints are thoroughly investigated and an appropriate response is given to complainants within a specified time frame and with regard to guidance in Local Authority Social Care and National Health Service Complaints (England) Regulations (2009) and CQC's Fundamental Standards. Appropriate action will be taken when concerns / complaints are upheld or partially upheld. A complaints and compliments procedure that is publicised and available in an accessible format to Service users, to enable an individual or someone acting on their behalf to make a complaint, must be maintained by the Provider, these will be consistent with the requirements of the Care Standards Act 2000 and the NHS Constitution Act 1990. An up to date log of all complaints, concerns and compliments received will be kept and the Provider will ensure that BNSSG ICB is informed of all complaints relating to the services it commissions. The Provider will regularly analyse the number and nature of complaints and compliments to establish trends, and takes action to implement service improvements as a result of the learning from complaints.
Well-led	Staff Training, Supervision and Appraisal The Provider will ensure that regular appraisal is an essential part of staff development and quality improvement. The Provider will seek to include feedback from Service Users and their support network in reviewing staff performance. The Provider will ensure that all staff are trained and developed to the specific set of standards set out in the Care Certificate introduced in April 2015 and has been assessed for the skills, knowledge and behaviours to ensure that they provide compassionate and high quality care and support. Supervisors of care staff will be responsible for assessment against the standards of the Care Certificate. The Care Certificate is NOT a replacement for role and workplace specific induction training. The Provider will ensure that competence and knowledge is checked, developed and evidenced (Preceptorship) including that abilities and practice in giving appropriate nursing care to Service Users is evident and documented.
Well-led	Management & Leadership of the Home Care Services The Provider will foster strong leadership and management that ensure the service has a strong care and support focus that is person-centred and affords dignity, respect and independence for all Service Users. The service develops their Management staff to take responsibility for delivering a high quality service and retains high quality staff.
Well-led	Communication The Provider will maintain and promote effective communication skills between Service users, their support networks and Staff and vice versa. Where the Service User has cognitive or sensory impairment or when an interpreter is required, the Provider will ensure that alternative methods of communication are made available.

The outcomes information will be captured through the contract monitoring process as outlined in Schedule 4, Quality Requirements.

3. Scope

3.1 Service Description and Pathway

The Services are commissioned by NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) for the care of Service Users who have been assessed as eligible for NHS Continuing Healthcare (CHC), including Fast Track, in accordance with the NHS National Framework for Continuing Healthcare.

3.2 NHS Continuing Healthcare

All care packages apply to a package of care that is arranged and funded solely by the NHS for people aged 18 years and older.

CHC patients will need to be assessed and meet the nationally determined CHC criteria. Ongoing eligibility is subject to regular review and assessment by the ICB's CHC service. Patients who meet CHC criteria have a 'primary health need' and typically have care needs that are complex, intense and unpredictable and therefore require care to be delivered by well trained staff who can provide a flexible and reliable service. Care packages may involve long term care or short term interventions and are tailored to meet individual need.

Patients who meet CHC Fast Track will have been determined by an appropriate professional to have a 'rapidly deteriorating condition and the condition may be entering the terminal phase'. The Fast Track pathway is designed to enable needs to be met to enable patients to die in their own home or in a care setting.

The Service Provider will be required to:

- Ensure all Service Users are case managed and have an individual person centred person centred care plan
- Ensure individual care packages are subject to ongoing review and performance management through an Individual Service Agreement
- Assessing individuals' on-going needs and responding to changes

4. Referral and admission process

4.1 Pre-provision assessment

The mutual agreement of the NHS Standard Contract, signed by both the Commissioner and the Provider, must be in place before the following process can be undertaken. Prior to this, the Commissioner must assure themselves of the following:

- Have there been any financial concerns or issues raised regarding the Provider
- Have there been any safety concerns or issues raised
- What is the CQC rating and report on the Provider

4.2 Pre-requisites to Placement

Prior to the commencement of the Care Package, the Commissioner sends the Provider:

- a copy of the needs assessment
- a copy of an outline Care Plan where available
- care hours information; and
- a proposed care start date.

The Provider will then:

- conduct a Care Consultation by the Provider or a Trusted Assessor;
- confirm within 48 hours of receipt of the referral if the referral is accepted or not; and
- agree the care start date specified by the Commissioner (if the referral is accepted).

In some circumstances, the Commissioner may request a care package to commence within 24 hours. Upon receipt of these requests the Provider will confirm by telephone with the Commissioner that:

- the Services can commence within the required timeframe;
- Care Workers are available; and
- a Care Consultation can be undertaken by the Provider or a Trusted Assessor.
- Provide the Commissioner with clear rationale for not accepting a referral, expected to be due to unavailability of staff or lack of appropriately skilled staff only.

Where a Care Consultation cannot be undertaken prior to the commencement of care, initial visits will be carried out by Care Workers trained to undertake a Care Consultation and competent to provide the required care.

4.3 The Care Consultation

- includes a Risk Assessment;
- establishes the Service User's needs;
- captures Service User's preferences, to include call times and tasks; and
- informs a detailed Care Plan.

A qualified Provider representative or a Trusted Assessor will conduct the Care Consultation. The Care Consultation will be conducted with the Service User and the Service User's family and Carers as appropriate.

4.4 Referral acceptance

By accepting the referral, the Provider confirms that they can meet the Service User's needs. If the Provider cannot meet the Service User's needs, they must reject the referral. The Provider may also reject the referral in accordance with clauses within the NHS Contractual Service Conditions.

4.5 Care package agreement

The care package is agreed by the Commissioner and the Provider.

The final decision on the care package remains with the Commissioner. The decision will be informed by the Provider and the MDT where necessary.

4.6 Individual Placement Agreement

In principle, the price for delivery of the service is set out in the Individual Placement Agreement (IPA) completed by the Commissioner and Provider in advance of each individual placement and not in the service specification.

The IPA describes that care package that the Service User is receiving (and which agreed price therefore applies) or, if necessary, describe a bespoke package and price.

The IPA needs to be signed by both the Commissioner and the Service Provider within 48 hours of receipt. Should the Service Provider not sign and return the IIPA to the Commissioner, the Commissioner will assume that the Service Provider has accepted the conditions and will deliver the service as agreed within the IPA and within this Contract.

4.7 Fast Track Pre-care package assessment (block contract providers)

The Service Provider will not be expected to meet the service user prior to service commencement. The service user will have been approved for Fast Track by the ICB Fast Track End of Life Team who will have reviewed the individual's care and support needs. A care needs summary or care plan detailing the care provision required to commence the package of care will be shared with the Provider. The Provider is expected to commence services within 2 days of referral.

In exceptional circumstances the Provider will be requested to meet and assess the Service User prior to acceptance to the service. This will be at the discretion of the ICB Fast Track End of Life Team.

The Commissioner will be responsible for quality assurance reviews of the Service Provider and reserves the right to inspect and review the care package without prior notice.

4.8 CHC review

The Commissioner will ensure Service Users are reviewed for their ongoing eligibility for CHC at the latest three months after the first CHC assessment, and annually thereafter, in line with the National Framework. Service Providers must ensure that they are aware of the date of the next proposed CHC assessment. Service Users will be asked if they want their representatives to attend the CHC assessment and outcome discussion.

The Commissioner will ensure CHC Fast Track Service Users are reviewed for their ongoing eligibility within three months of eligibility.

If, as a result of the CHC assessment or Fast Track review the Service User no longer meets the eligibility criteria the Service User will be referred to the appropriate Local Authority for onward assessment and support.

5. Activity Upon Service Commencement

5.1 General

The Service Provider will provide a reliable, cost effective, patient focused service of high clinical quality for Service Users. The Service will cover a range of activities that will support the needs and required outcomes detailed in the Care Plan and/or Advanced Care Plan.

5.2 Advocates

The Service Provider will:

- support Service User use of advocates as defined in CQC Fundamental Standards
- where appropriate ensure a suitably qualified independent advocate is available where an individual lacks capacity to make decisions
- ensure there is an independent advocate available where a conflict arises in the Service User's life and the Service User has no relatives or is particularly frail or vulnerable. In these instances the Service Provider will also notify the Commissioner
- inform any advocate representing a Service User of major changes in the Service User's life

5.3 Care Planning

Upon service commencement the Service Provider will develop a Person centered Care Plan in conjunction with the Service User. This initial person centered care plan must be received by the commissioner within 28 days (7 days for all fast track service users) of the Service commencement.

The Person centered care plan and/or Advanced Person centered care plan must demonstrate Service Users' individual needs, and the actions required to meet those needs. Plans must be implemented and reviewed and recording maintained in a contemporaneous manner.

Wherever possible the Service User shall be given a copy of the Person centered care plan and/or Advanced Care in their preferred language.

The Service Provider must maintain a care record, which details, in English, all the care provided to a Service User to confirm that the Person centered care plan and/or Advanced Person centered care plan has been implemented. This record must be standardised and include, but not be limited to:

- the date and time care was provided;
- the type and frequency of care provided;
- observations which may be relevant to need; action to be taken and the name of the person responsible; and
- the signatures of the Staff members providing the care.

The Service Provider must review Service Users' Person centred care plans and/or Advanced Person centred care plans monthly (minimum) which must involve a formal review with the Service User and be updated as the Service User needs change.

Significant changes to the Person centred care plan and/or Advanced Person centred care plan that result in additional cost or reduced cost must be notified and agreed to and by the Commissioner.

All Care Plans should be made available to the Commissioner on request and any changes in the care plans should be shared with the Commissioner within 48 hours of completion.

The Service Provider must ensure the availability of a Medicines Administration Record, which details, in English, information about the Service User and any medicines they are currently prescribed. This record must show:

- The Service User's name, address and date of birth
- Any drug allergies
- A list of all the current medicines prescribed; including name, strength, dose and frequency
- The receipt of any medicines brought in or obtained for the Service User

6. Ongoing Care

The Service Provider will ensure regular assessment of the Service User on going needs in accordance with CQC Fundamental Standards.

The Service User, their advocate, the Commissioner or the Service Provider may request a review of the Service User's needs at any time. If there is a significant change in the Service Users' needs or if the requirements of the existing Care Plan are not being met the Service Provider will notify the Commissioner or delegated officer as soon as is reasonably practicable

The Service Provider will meet the requirements detailed in Table 1. The Service User will not have all of these needs but where they exist the Service Provider is expected to identify and meet the requirements.

In addition to the requirements detailed in Table 1 the service provider should ensure that plans are in place to prevent avoidable hospital admissions.

The Service Provider will refer Service Users to specialist care as appropriate.

Table 1: Service User needs and requirements of Service Provider (non-exhaustive)

Needs:	Requirements:
Behaviour • aggression, violence or passive non-aggressive behaviour • severe dis-inhibition • intractable noisiness or restlessness and/or wandering • resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance, but see note below) • severe fluctuations in mental state • extreme frustration associated with communication difficulties • inappropriate interference with others • identified high risk of suicide	✓ understanding what can potentially trigger behaviour that presents a risk for each person or to others ✓ having Staff with the skills and knowledge to be able to respond immediately to reduce the likelihood of this behaviour happening or recurring
Cognition • marked short term memory issues • long term memory problems	

• disorientation to time and place limited awareness of basic needs and risks • difficulty making basic decisions • dependant on others to anticipate basic needs	✓ encourage Service User's family/friends to visit and bring in Service User's personal possessions (for instance, photographs) ✓ use reality orientation and validation techniques. ✓ have a communication strategy to assist Service Users to express needs and make decisions
Psychological and Emotional needs • unable to express their psychological/emotional needs • mood disturbance • hallucinations • anxiety • periods of distress • withdrawn from attempts to engage in daily activities	✓ assess, plan and deliver person-centred care ✓ prompts to motivate towards engagement with daily activities ✓ provide additional support to facilitate Service User involvement as required ✓ support Service User with life changing events ✓ recognise Service User depression and its effects on behaviour ✓ refer Service User to primary and acute care services ✓ staff must be skilled to recognise psychological and emotional problems and refer to appropriate services ✓ support Service Users' relationships (including partners, families and friends) ✓ have an activity programme tailored to meet the Service User's needs and prevent isolation
Communication (relates to difficulty with expression and understanding, not with the interpretation of language) • sometimes unable to reliably communicate • unable to express needs, even when assisted	✓ special assistance may be needed to ensure accurate interpretation of needs ✓ able to anticipate needs through non-verbal signs
Mobility • unable to consistently weight bear • completely unable to weight bear • high risk of falls • needs careful positioning • unable to assist or cooperate with transfers and/or repositioning • involuntary spasms or contractures	✓ have falls and moving and handling risk assessment and prevention strategies ✓ staff must be trained in moving and handling and falls prevention ✓ provide and maintain mobility equipment ✓ replace where necessary
Nutrition – food & drink • at risk of malnutrition, dehydration and aspiration • unintended weight loss or gain • Dysphagic • risk of choking • non-problematic/problematic tube feeding e.g. PEG	✓ staff must have training on the use of nutritional screening tools and use appropriately and routinely according to recommendations ✓ seek GP/ dietician advice when a significant change in weight occurs or increase in 'MUST' score above 2

• requirements for special diet for medical/cultural/religious reasons	✓ skilled intervention to ensure adequate nutrition/hydration and minimise risk of aspiration to maintain airway ✓ manage use of enteral tube feeds following specialist advice and seeking support as appropriate ✓ care for enteral tube +/- stoma site following specialist advice and seeking support as appropriate ✓ provide access to and assistance with (where required) nutritionally adequate diets for all Service Users, taking into account any special dietary requirements e.g. diabetes, texture modification ✓ provide access for all residents to nutritional complete menus that meet nutrition standards.
Continence • incontinent of urine and/or faeces • catheterised • requiring stoma care • chronic urinary tract infections	✓ recognise normal patterns and act on abnormal occurrences (seeking specialist advice as required) ✓ monitor for and act on any infection ✓ have appropriate management supervision and equipment (for instance, in relation to catheterisation, bowel management) ✓ have appropriate training in catheter and stoma care ✓ undertake continence assessments and promote continence with individual continence programmes
Skin (including tissue viability) - a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin. • skin condition that requires monitoring or re-assessment • risk of skin breakdown requiring intervention • pressure damage or open wound • open wound, pressure ulcer with full thickness skin loss and narcosis extending to underlying bone • care of stoma site	✓ have policies and procedures that comply with current NICE guidance ✓ train Staff to promptly recognise and act on changes to risk factors as per CQC Fundamental Standards Regulation 18 and 19 ✓ have equipment to maintain skin integrity ✓ manage skin conditions ✓ care for enteral tube +/- stoma site (following specialist advice and seeking support as appropriate) ✓ have evidence-based wound management policy that meets local tissue viability referral criteria ✓ have a nominated tissue viability link nurse for each home who undertakes training in wound care to recognise problems as they occur and seek specialist advice
Breathing • shortness of breath which may require the use of inhalers or nebuliser • episodes of breathlessness that do not respond to management • requires low level oxygen therapy	✓ staff must be trained to use equipment and oxygen to support Service User breathing as prescribed (for instance, nebulisers, CPAP and tracheostomy equipment)

• requires CPAP (continuous positive airways pressure) • breathing independently through a tracheostomy • difficulty in breathing which requires suction to maintain airway	
Drug therapies and medication • requires prompting, supervision and assistance with administration • non-concordance with therapy or compliance issues • administration of complex medication • medication via enteral tube e.g. PEG • requires ongoing pain control EOLC (including Controlled Drugs) • reporting of adverse events, adverse drug reactions, incidents, errors and near misses	✓ monitor fluctuating conditions and managing side effects ✓ have a written procedure for medicine management which includes managing non-concordance and non-compliance ✓ ensure referrals for medication reviews at least every six months and/or as required ✓ use a range of methods to assess pain including a validated pain screen tool administer all medicines in accordance with a valid prescription and according to the directions on the pharmacy label ✓ administer analgesia as prescribed and monitor effect using pain assessment tool ✓ use non-pharmacological methods to reduce pain and discomfort ✓ manage medication for rapidly deteriorating or changing conditions ✓ have a system to prescribe (and store in the home) anticipatory end of life drugs ✓ staff must be trained in administering complex medication including via enteral tube e.g. PEG ✓ access medications in most suitable format for administering via enteral tubes ✓ staff are trained in the use of syringe drivers
Altered states of consciousness – can include a range of conditions including stroke and epilepsy.	✓ undertake and regularly review risk assessments. ✓ implement individualised epilepsy management plans.
End of life care	✓ involve Service Users and their family/friends (as appropriate) in planning for their EOLC. ✓ act in accordance with a Do Not Attempt Resuscitation (DNAR) status if this has been recorded in the Service User's medical notes ✓ offer Advance Care Plans (ACPs) to Service Users at appropriate intervals. Review ACPs as required ✓ train all Staff in end of life identification, planning and coordination skills in line with a model such as the Gold Standards Framework ✓ manage Service User care in final days of life using evidenced based tools

	✓ manage care in line with the "NICE quality standard for end of life for adults" ✓ develop links with community palliative care team

6.1 Interdependence with other services / providers

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 and community sector and independent providers.

The Service Provider must demonstrate how it will work with these other organisations to support Service Users and their carers to successfully manage the 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

6.2 Access to primary healthcare services

Primary healthcare providers are expected to deliver their services. If they do not provide the services this should be raised with the Commissioner who will work with primary healthcare providers and the Service Provider to resolve it.

6.3 Coordination with CQC and Local Authorities

Where possible the Commissioner will work with CQC, if applicable, and Local Authorities regarding contract monitoring and quality assurance to avoid duplication.

6.4 Equipment

If, following a clinical review it is identified that the Service User requires equipment, the ICB will lead the process of liaison with relevant agencies to facilitate supply through the BNSSG Community Equipment services.

The Service Provider shall inform the ICB CHC team if it believes that equipment is no longer be required so that an appropriate review can be arranged.

In exceptional circumstances where equipment in not available from BNSSG CCG Equipment services specialist items may need to be purchased by the commissioner. The Service Provider will ensure that any clinical equipment provided for the Service User by a Commissioner is:

- Managed and operated safely and securely
- Operated in line with the manufacturer's instructions
- Made available for maintenance by the Commissioner
- Kept clean and decontaminated as per infection control policies and procedures. Where necessary, items of equipment which need to undergo specialist decontamination, the Commissioner will provide instructions to the Service Provider

The Commissioner retains title of any equipment provided for the Service User but the liability for the safe use and maintenance remains with the Service Provider.

In the event of the equipment no longer being required for the Service User for whom the equipment was identified, the Service Provider must advise the Commissioner within 24 hours in order that arrangements can be made for the equipment's collection.

6.5 Clinical governance

The Service Provider will:

- Work with the Commissioner to establish systems and procedures of clinical governance which would include participating in performance management processes and audits to promote continuous improvement in the quality of care services and to safeguard high standards of care by creating an environment in which care will continually develop. For the avoidance of doubt, the Service Provider agrees that the Commissioner has the right to audit at any time by giving 24 hours' notice to the Service Provider;
- Allow the Commissioner or any representative of a Commissioner to enter and to inspect the Services being provided at any time without notice. The Service Provider shall ensure that all Staff provide full co-operation to a Commissioner or relevant representative and shall provide access to all relevant documentation regarding the provision of the Service. In the event that the Commissioner considers that there are deficiencies in the Service then it may issue a Performance Notice which identifies the deficiencies and sets out an action plan for remedy.
- Participate and cooperate with the Commissioner on all investigations.
- Undertake and complete agreed actions where the Commissioner has provided an action plan or suggestions for improved performance.
- Participate in the re-measuring and re-auditing of performance management issues.
- Maintain a care record, which details, in English, a contemporaneous ongoing evaluation of the Service User's current care plans as detailed in Section 3.4. The Care Plan must be in a format that is accessible to the Service User family/carers.
- Ensure that a signatory register is maintained which includes the names and signatures of all staff involved in the provision of care.

6.6 Whole system relationships

The Service cannot work in isolation of other commissioned health services and the Service Provider will work co-operatively with the following:

- Hospital Discharge Liaison Team
- The Commissioner's CHC Assessment Team
- The Commissioner's District Nursing Teams; specialist nurses such as diabetes, respiratory, tissue viability, continence advisors and Palliative Care Services
- Specialist Nurses e.g. nutrition
- General Practitioners
- Allied health professionals such as Physiotherapists; Speech and Language Therapists; Dietitians; Pharmacists; Occupational Therapists; Podiatrists
- Social Care

- Voluntary sector
- Ambulance/Patient Transport Services
- Forensic Services

6.7 Safeguarding

The Service Provider will adhere to local up to date safeguarding polices and relevant procedures, and will have in place an active training plan for staff, ensuring that all clinical and managerial staff receive training in Adult Safeguarding and the Mental Capacity Act.

The Service Provider will ensure staff understand and apply the Deprivation of Liberty (DoLs) safeguarding in practice.

The Service Provider will operate a safe recruitment policy and procedure, and all staff in contact with Service Users having a full DBS check in full, disclosure and barring service (DBS).

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 the Commissioner at the same time.

6.8 Challenging Behaviour

Challenging behaviour must be considered in the context of the environment in which it occurs, the way the Service is organised and the needs of the Service User.

People who present with behavioural challenges can and should be supported to engage in activities that promote optimum quality of life and with support that ensures protection of their human rights. They should not be subject to inappropriate, punitive or harmful restrictions, ineffective treatments or unjustified and excessive use of medication.

The Service Provider must have a policy to positively engage and support Service Users who demonstrate challenging behaviour which take account of all relevant legislation, guidance and good practice.

Continuing behaviour of a disruptive nature will require a consistent response by staff. The Service Provider must be aware of and have plans for known challenging behaviour in the Service User's Person centred care plan.

- Challenging behaviour' is a socially determined construct. Positive Behavioural Support approaches should provide a basis for focussed assessment, formulation and interventions on the relationship between the individual and their environment, rather than on the elimination of behaviours.

- The Service Provider will deliver effective and safe support of people who present with behaviours that challenge services.

- Service Providers should work with the individual, families, professionals and other community resources to deliver interventions and support.

- Interventions will be delivered as part of an agreed multi professional care and treatment approach and must be based on a clear, comprehensive and agreed support plan.

Priority outcome measures for interventions should focus on quality of life and the protection of human rights. The use of restraint, as a last resort, must be in accordance with the Mental Capacity Act 2005, its amendment, The Deprivation of Liberty Safeguards and CQC Guidance. Staff responsible for the management of challenging behaviour and the use of restraint must be appropriately trained and work to the individual services' agreed operational guidelines to maintain best practice in relation to control and restraint.

The Service Provider will work with the Commissioner to take all reasonable steps to resolve issues as and when they arise. Termination will only occur if all other demonstrable efforts to resolve issues have been unsuccessful. All reasonable endeavours will be undertaken to mitigate a Service User's termination of the care package.

If, despite all reasonable endeavours to resolve issues the Service Provider wishes to terminate an individual care provision agreement, it shall do so in accordance with the provision of this contract. On receipt of the notice of termination the Commissioner shall use reasonable endeavours to arrange for an alternative placement for the Service User within the 28 days. However, where the Commissioner has not reasonably been able to transfer the Service User within 28 days, then the Individual Placement Agreement shall not be terminated until the Commissioner has arranged an alternative placement and moved the Service User to that placement. In the instance of behaviours displayed by the Service User as causing safety risks then the Service Provider and the Commissioner may agree an eviction notice of less than 28 days where an alternative placement can be sourced within that period. The Commissioner may also agree a level of enhanced support as an interim measure to maintain the safety of the Service User and staff.

6.9 Absence

A Service User may take a planned trip and go out (for instance, with family and friends).

On these occasions the Service Provider will complete a risk assessment in conjunction with the Service User (and the person or persons accompanying them) prior to the outing. The risk assessment should address the care the Service User should receive (including timely administration of medication and nutrition, noting plans for how special dietary requirements e.g. diabetic diets, will be met) and when the Service User is due to return home

A person may not be deprived of their liberty unless under Deprivation of Liberty Safeguards as set out in the Mental Capacity Act 2005**.**

On occasions where an individual is planning a longer trip the Service Provider will: apply the same principles re: planned trips to longer periods of agreed leave;

- inform the Commissioner of the period of leave in advance of the period of leave;
- agree a risk assessment process with the Commissioner in advance of the period of leave;
- where appropriate negotiate a retention period and rate with the Commissioner as required.

6.10 Unplanned absence

If a Service User does not return as planned following agreed leave, the Service Provider will try to contact the Service User and those accompanying them to establish if there is a problem. If the Service User cannot be contacted, the Service Provider should instigate

escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert.

If the Service User leaves the home/placement without notifying the Service Provider, the Service Provider should instigate escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert.

The Service Provider will notify the Commissioner of the unplanned absence within one working day.

The Service Provider will adhere to the reporting requirement for Service Users receiving care under any section of the Mental Health Act as appropriate.

The Service Provider will hold the Service User's room for a period of seven days which the Commissioner will fund. If the Service User does not return within seven days the individual placement will cease unless the Commissioner and Service Provider negotiate an extended retention period.

6.11 Access to NHS secondary and tertiary care services

6.11.1 Transport

The Service Provider will arrange transport for Service Users attending secondary and tertiary care service appointments. The Service Provider should liaise with the appointment provider regarding return transportation. The cost of transport for NHS-related appointments will be funded by the NHS. For non-NHS related appointments the cost of transport will not be funded by the NHS.

6.11.2 Accompaniment/Escort

The Service Provider will ensure the Service User is accompanied appropriately to the level of risk and care need associated with the appointment.

The first four hours of escorting will not be charged as an additional cost to the Commissioner. Provider escorting required beyond the first four hours will be charged at the hourly rate agreed by the Commissioner.

In the case of hospital admission, the Service User will remain accompanied up until the point of admission.

6.11.3 Communication

The Service Provider will alert the appointment provider of any Service User interpretation and communication requirements prior to the appointment.

6.11.4 General principles

The Service User's placement with the Service Provider will remain open to the Service User for a period of six consecutive weeks.

The Commissioner may negotiate the extension of the Service User's placement longer than the standard six week retention period as required.

6.11.5 Activity supporting Service User admission into hospital

Upon admission into hospital or another provider the Service Provider will inform:

- the Service User's next of kin/ a named representative as soon as possible
- the Commissioner verbally and via email/letter within 24 hours
- the Service User's GP within 24 hours

The Service Provider will maintain contact with the hospital throughout the Service User's stay and be involved where necessary in discharge planning processes**.**

6.11.6 Activity supporting existing Service User discharge from hospital

Prior to the Service User's discharge from hospital the Service Provider will review the Service User's clinical needs to ensure they can be met by the Service Provider. This review should be carried out within the timescales stipulated in the Quality Schedule.

If the Service Provider can continue to meet the Service User's needs, upon re-admission to the Home the Service Provider will inform:

- the Service User's next of kin/ a named representative of the re-admission as soon as possible
- the Commissioner of the re-admission verbally/email/in writing within 24 hours
- the Commissioner of any revisions to the Care Plan within 48 hours of re-admission

In exceptional circumstances where the Service Provider can no longer meet the clinical needs of the Service User, the Service Provider will notify the Commissioner as soon as possible explaining the rationale for no longer being able to care for the Service User.

6.11.7 Activity supporting new Service Users' discharge from hospital

The Service Provider will assess new potential Service User's clinical needs to ensure they can be met by the Service Provider. This review should be carried out within the timescales stipulated in the Quality Schedule.

If the Service Provider can meet the Service User's needs, prior to admission to the Home the Service Provider will inform:

- the Service User's next of kin/ a named representative of the admission as soon as possible
- the Commissioner of the admission verbally/email/in writing within 24 hours
- the Commissioner of any revisions to the Care Plan within 48 hours of admission

To aide safe discharges, for each discharge from hospital to the Service Provider, the Service Provider shall complete a Transfer of Care Document provided in Schedule 2 J. A copy of this should be kept in the patient's file.

6.12 Service User Death

Service User deaths fall into three (3) categories: expected death, sudden unexpected death and suspicious death. The Service Provider will comply with NHS Standard Contract Service Conditions and the CQC Fundamental Standards and take into account any cultural requirements in relation to death of a Service User and any arrangements required.

For expected deaths the Service Provider shall:

- notify the Service User's next of kin/a named representative as soon as is reasonably practicable, so that suitable arrangements (including burial/cremation) can be made
- contact the Service User's GP and ensure that an appropriate doctor certifies the death immediately
- notify the Commissioner verbally within twenty-four (24) hours of the death
- confirm the verbal notification to the Commissioner in writing within forty-eight (48) hours of the death

For sudden unexpected deaths the Service Provider shall:

- notify the Service User's next of kin/a named representative as soon as is reasonably practicable
- contact the Service User's GP immediately and any other individual or organisation required by the GP; or where the Service User's GP cannot be contacted shall contact the police
- ensure that the Commissioner is notified verbally within twenty-four (24) hours of the death
- confirm the verbal notification to the Commissioner in writing within forty-eight (48) hours of the death

For all suspicious deaths the Service Provider shall:

- contact the Service User's GP and police immediately
- notify the Service User's next of kin/a named representative as soon as is reasonably practicable
- notify the Commissioner as soon as is reasonably practicable, and within one working day of the death
- confirm the notification in writing within 48 hours of the death

For suspicious deaths and sudden unexpected deaths where the GP and/or police need to attend the scene, the body will not be moved once death has been verified and the area will be vacated and left undisturbed.

The Service Provider will ensure that the Service User's medicines are managed in accordance with CQC Fundamental Standards and NICE guidance relating to medicines. The Service Provider will ensure that the Service User's medicines are retained for a period of seven (7) days in case there is a coroner's inquest.

7. Termination Processes

7.1 Termination of NHS Standard Contract

Except as provided below, the Commissioner on giving twenty-eight (28) days' Notice in writing may terminate the Home Care contract.

Except as provided below, the Service Provider may terminate the Continuing Healthcare Home Care contract by written notice which shall be no less than twenty-eight (28) days (unless the Commissioner otherwise agrees) and the Continuing Healthcare Home Care contract under no circumstances terminate until the Commissioner has (using its reasonable endeavours) located and transferred the Service Users to an alternative care provision.

Payment by the Commissioner to the Service Provider is made from the date of service commencement on a monthly basis for the duration of the project. If the Continuing Healthcare Home Care contract is terminated as a result of breach of this contract by the Service Provider payment will cease to be made on the day of service termination. The notice will give reasons why the care contract is being ended.

All Individual Placement Agreements will be terminated on termination of this Service Specification. No new Individual Placement Agreement contracts will be entered into if notice of termination of this Service Specification has been served.

In the event of termination of Home Care contract, the Commissioner and the Service Provider will work together in good faith to safeguard the interests of the Service User until such time as an alternative arrangement can be made.

7.2 Termination of Individual Placement Agreements

Except as provided below, the Commissioner on giving fourteen (14) days' Notice in writing may terminate an Individual Continuing Healthcare Home Care agreement.

The Service Provider may terminate the Individual Placement Agreement by written notice which shall be no less than fourteen (14) days' (unless the Commissioner otherwise agrees) and the Individual Placement Agreement shall under no circumstances terminate until the Commissioner has (using its reasonable endeavours) located and transferred the Service User to an alternative provider.

Should the Service User or the Service Users Representative wish to change providers, an agreement will be arranged with the current provider and the commissioner on the notice period. However in most cases, packages of care will end on the day before the new service starting, unless agreed otherwise by the commissioner

Should there be a death of a service user being supported then the Individual Placement Agreement will end on the date of death. No further funding for that particular package of care will be provided to the Provider unless agreed otherwise in exceptional circumstances by the Commissioner.

The Commissioner may terminate the Continuing Healthcare Home Care contract with immediate effect, where it is agreed:

- Service User's needs can no longer be met or
- The care arrangement has broken down or
- Where there is potential for significant harm to Service Users

In cases where the Service User has become ineligible for financial assistance from the Commissioner, the Commissioner shall have the right to terminate the Individual Continuing Healthcare Home Care contract to the Service Provider as provided in the Individual Continuing Healthcare Home Care contract. The Service User will from this date take financial responsibility for their care package.

7.3 Termination of Block Contract Arrangements

Termination of Block Contract Arrangements should be agreed with the commissioner by a notice period of 3 months form the date in which the Provider or Commissioner gives notice.

The Commissioner and Provider should work together proactively to ensure continuity of care for the Service Users. The Provider may be asked by the Commissioner to work continue to support Service Users past the agreed notice period date.

Termination of a Block Contract Agreement does not terminate this Agreement. Should notice be given on the Service Specification then all Individual Care Provision Agreements will be terminated on termination of this Service Specification. No new Individual Care Provision Agreements will be entered into if notice of termination of this Service Specification has been served.

However, if active discussions are proceeding with a prospective purchaser of the provider covered under this contract and the new proprietor intends entering into a contract, then consideration may be given by a Commissioner to continue making new care arrangements.

8. Location of Provider Premises

The Provider's Premises are located at:

[Insert name, address of service location]

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service name
NHS BNSSG ICB Care Home Specification 2022-2024

Service specification number
01 - 2022

Population and/or geography to be served
This Specification relates to Service Providers operating within the BNSSG boundaries. On occasion services may be commissioned for service users living outside of these boundaries. All service users will be registered with a BNSSG General Practitioner at the point of CHC eligibility determination

1. Introduction

This document is the Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) specification for Care Home services. It relates to all Service User groups where BNSSG ICB is responsible for full funding of the package of care.

1.1 Core Principles

The overarching core principles for the provision of Care Home Services that underpin the expected delivery of care are as follows:

Providers of Care Home services will:

i) Promote high quality of life for Service Users as paramount.
ii) Recognise that Service Users are individuals, and not defined by their health condition or disability.
iii) Recognise and uphold the diversity, values and human rights of people using the service.
iv) Uphold Service Users' privacy, dignity and independence.
v) Provide information that supports Service Users and their support network, to understand the care, treatment and support and to make decisions about it.
vi) Enable Service Users to care for themselves where possible, maximising their independence, working with a reablement approach wherever possible.
vii) Encourage Service Users and their support network to be involved in how the home is run and to ensure the service feels homely.
viii) Ensure that the views and wishes of Service Users are paramount in the delivery of their care.

1.2 Quality Assurance and Monitoring

BNSSG ICB requires the provider where applicable to be registered with the Care Quality Commission (CQC) and that standards never fall below their Fundamental Standard Regulations.

Providers will be required to take responsibility for the quality and quality assurance of all aspects of their services.

BNSSG ICB's relationship with the provider is separate to the role of the regulator (CQC).

BNSSG ICB's responsibility is for monitoring how the Provider is performing under the NHS contract. BNSSG ICB will check that Providers deliver high quality care and support to all service users for all their services by means of quality assurance visits. These may be unannounced.

1.3 NHS email system

The Provider will ensure that they can receive emails from the Commissioner and send electronic communications to the Commissioner using an encrypted email system.

NHS England are supporting the enablement of secure email accounts for Care Home providers to safely exchange patient or sensitive information with other health and social care professionals via NHSmail. To join NHSmail via the national administration registration process please use the online registration portal tool here:

https://portal.nhs.net/Registration#/careprovider

The Provider will ensure there are always sufficient staff that are suitably trained and available to access and acknowledge receipt of all secure emails within one operational day of the email being sent by the Commissioner.

Providers will have arrangements in place to rapidly respond to invitations to provide service for those individuals at end of life.

The Commissioner will expect the Service Provider to have at least one NHSmail address in use to share secure information.

2. Outcomes

2.1 NHS Outcomes Framework Domains and 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**	✓

Where appropriate as agreed with commissioners the Service Provider will report on individual care and progress or significant changes in packages of care.

2.2 Local Defined Outcomes

Domain 1: Preventing people from dying prematurely

- ✓ Dying with dignity/better coordinated and planned end of life care
- ✓ Reducing premature death in people with serious mental illness and/or a learning disability
- ✓ Ensuring Service Users are regularly reviewed and any developing problems are treated as soon as possible.

Domain 2: Enhancing quality of life for people with long-term conditions

- ✓ Proactive approach to care and treatment
- ✓ Care is delivered with re-ablement as the core outcome.
- ✓ Prevention of hospital attendances and admissions related to long term conditions, mental illness or poor nutrition

Domain 3: Helping people to recover from episodes of ill-health or following injury

- ✓ Effective discharge management and prevention of readmission

Domain 4: Ensuring people have a positive experience of care

- ✓ Service Users will have agreed person centred care plans detailing specific outcomes for each individual.
- ✓ Service Users will be offered the opportunity to partake in activities of interest to them.
- ✓ Service Users' care will be delivered in a culturally appropriate manner taking their lifestyle choices into consideration.

Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm

- ✓ Preventing avoidable and non-elective hospital attendances and admissions
- ✓ Better use of primary care/GP practice resources
- ✓ Effective, timely, evidence-based and appropriate use of medicines and nutritional supplements
- ✓ A stable and appropriately trained workforce
- ✓ Appropriate use of extra resources (i.e. 1:1) to ensure the safety of Service Users.
- ✓ Service Users and relatives feel safe and protected by the Service Provider and know how they can raise a concern or complaint as to how care is being delivered.

2.3 Service Specific Outcomes

Service Specific Outcomes	
Safe	<u>Service Users are Safe</u> The Provider will protect Service Users from fear, abuse and neglect by ensuring staff are aware of their duties relating to Safeguarding under the Care Act 2015 and receive comprehensive training on the awareness and prevention of abuse. The Provider will have in place a clear process and associated documentation for recording allegations of abuse. The Provider will ensure that the CQC, if applicable, and BNSSG ICB are informed of all safeguarding concerns.
Safe	<u>Mental Capacity Act & Deprivation of Liberty Safeguards</u> Providers will support Service Users as much as possible to make their own decisions; anything done for or on behalf of people without capacity is the least restrictive to their basic human rights and done in their best interests. The provider will have in place a clear procedure that sets out the actions required of staff in relation to Service Users who do not have the capacity to make decisions and will ensure that all staff are trained and able to demonstrate knowledge and practice of the Mental Capacity Act and Deprivation of Liberty Safeguards. Assessments of capacity and best interest decisions (Mental Capacity Act) will be reviewed by the provider on at least a monthly basis.

Safe	Reviews The provider will undertake regular reviews of Care and Support Plans that involve the Service User, the Commissioner and the Service User's support networks to ensure that the Service User's needs as required by the care provision continue to be met. To demonstrate that the outcomes of the care provision are being met, the provider may be required to respond to information requests in relation to the Service Users Care & Support plan that are made by BNSSG ICB The provider will comply with individual case reviews undertaken by ICB appointed staff.
Caring	End of Life Care The Provider will work within NICE's guidelines for end of life care to ensure that the physical, emotional and spiritual needs of Service Users are met and that they live out their lives in as dignified and peaceful a manner of their choosing. https://www.nice.org.uk/guidance/qs144 Care delivery will be managed in accordance with "One Chance to get it Right" https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-progress. Where possible, Services Users are involved in the assessment and planning of their End of Life Care. To meet the Service Users wishes in the event of death, an Advance Person-centred care plan should be in place that is linked to the GP notes and is clearly documented in the Service Users Care & Support Plan.
Caring	Person Centered Care The service promotes and embeds person-centered care as standard practice in care planning and delivery so that Service Users are treated as individuals with unique backgrounds, qualities, abilities, interests, preferences and needs. The Service User will be allocated a key worker who understands their individual needs and preferences and regularly liaises with the Service User's support network.
Responsive	Dignity & Respect The Provider will actively promote dignity, respect and independence ensuring that Service Users have a Care and Support plan that refers to their personal wishes, preferences and priorities and to the support they need in order to retain their dignity and develop their sense of personal identity.
Responsive	Equalities The Provider must ensure that Service Users do not experience direct or indirect discrimination, harassment or prejudice arising from their age, disability, race, sex, gender reassignment (transgender), sexual orientation, marriage and civil partnership, pregnancy and maternity and religion and belief (including those with no religion and belief) in the way services are provided or in the way they are treated by staff, other Service Users, visitors, family and friends.
Responsive	Choice, Control & Engagement The Provider will promote Service User choice and control. Service Users will be in control of their own life and if possible, will be encouraged to live independently in the community with an appropriate support provider if they so wish. The Service User will be consulted as to what their needs, wishes and preferences are in all aspects of their life, including participation in activities in the community and these will be recorded in the Service users Care & Support Plan.

Effective	Quality Assurance The Provider will facilitate unannounced quality assurance visits from BNSSG ICB. BNSSG ICB will issue a report to the Provider within 12 working days of the completion of the visit unless otherwise indicated, comprehensive verbal feedback will be given on the day at the end of the visit. The Provider ensures that where BNSSG ICB or CQC, if applicable, have issued compliance actions or recommendations for service improvement, these are incorporated within a service improvement plan and action taken as per the timescales agreed with the BNSSG ICB / CQC. This may include an improvement plan arising from the safeguarding process in Bristol and/or another relevant local authority. The service improvement plan will be shared with BNSSG ICB.
Effective	Management of Health & Wellbeing? The Provider will ensure that unnecessary admissions to hospital are avoided through proactive management and review of Service Users' health and wellbeing needs including: ▪ Screening for risk of malnutrition using a validated tool such as MUST. Providers must ensure that service users have access to a wide range of food and drinks and that food and drink intake is monitored and recorded for those identified as malnourished or at risk of malnutrition. ▪ Staff are trained to recognise the verbal and physical signs of pain. The provider must ensure that any change in health status or behaviour is recorded and that evidence is maintained of health appointments / referrals for specialist advice. ▪ Assessment of foot care needs of the Service User by an appropriately trained health professional is made within 4 weeks of admission and recorded in the Care and Support plan. ▪ Maintenance of oral comfort and hygiene of Service Users ▪ Assessment of tissue viability is undertaken on service commencement. Pressure areas must be reviewed regularly using the SSKIN Care bundle and pressure relieving equipment is provided as appropriate. All Category 3 and 4 wounds must be referred to the NHS tissue viability service and reported to the CQC, if applicable. ▪ A falls risk assessment is completed within 24 hours of the Service User's admission and the outcome recorded in the Care and Support Plan. Those Service Users who are vulnerable to falls are actively supported by their key worker or equivalent member of care / nursing staff to reduce / prevent the risk of a fall occurring and thereby supporting a reduction in unnecessary emergency admissions related to falls. The provider will maintain a register of falls, undertaking audits to ensure that necessary actions are taken to reduce falls and avoid unnecessary admissions to hospital ▪ The Provider will ensure that prescription-only medicines are administered in accordance with a valid prescription. All administration errors are recorded as a clinical incident and reported to CQC, if applicable, and advice is sought from the GP or pharmacist. The Provider will ensure that any decision to covertly administer medication is documented in the Service Users' Care and Support Plan, including information on: - Decision specific Mental Capacity Assessment. - Best Interest decision and reason for convert administration of medication. - That the suitability of administering the medicines with food and drink has been checked with a pharmacist. - Whether the Service User is likely to recover so as to be capable of making their own treatment decisions in the near future. - The Provider will ensure regular reviews are undertaken to assess the continued appropriateness of covert administration where this occurs.

Effective	Mental Well Being The Provider will maintain an environment that promotes mental wellbeing and provides opportunities for Service Users to meet their mental health needs as appropriate. Working with other relevant services, the Provider will ensure that Service Users' mental health needs are met and that Service Users are able to maintain an acceptable level of mental wellbeing.
Effective	Complaints The Provider will have a process in place that ensures that all concerns and complaints are thoroughly investigated and an appropriate response is given to complainants within a specified time frame and with regard to guidance in Local Authority Social Care and National Health Service Complaints (England) Regulations (2009) and CQC's Fundamental Standards. Appropriate action will be taken when concerns / complaints are upheld or partially upheld. A complaints and compliments procedure that is publicised and available in an accessible format to Service users, to enable an individual or someone acting on their behalf to make a complaint, must be maintained by the Provider, these will be consistent with the requirements of the Care Standards Act 2000 and the NHS Constitution Act 1990. An up to date log of all complaints, concerns and compliments received will be kept and the Provider will ensure that BNSSG ICB is informed of all complaints relating to the services it commissions. The Provider will regularly analyse the number and nature of complaints and compliments to establish trends, and takes action to implement service improvements as a result of the learning from complaints.
Well-led	Staff Training, Supervision and Appraisal The Provider will ensure that regular appraisal is an essential part of staff development and quality improvement. The Provider will seek to include feedback from Service Users and their support network in reviewing staff performance. The Provider will ensure that all staff are trained and developed to the specific set of standards set out in the Care Certificate introduced in April 2015 and has been assessed for the skills, knowledge and behaviours to ensure that they provide compassionate and high quality care and support. Supervisors of care staff will be responsible for assessment against the standards of the Care Certificate. The Care Certificate is NOT a replacement for role and workplace specific induction training. The Provider will ensure that competence and knowledge is checked, developed and evidenced (Preceptorship) including that abilities and practice in giving appropriate nursing care to Service Users is evident and documented.
Well-led	Management & Leadership of the Care Home Services The Provider will foster strong leadership and management that ensure the service has a strong care and support focus that is person-centred and affords dignity, respect and independence for all Service Users. The service develops their Management staff to take responsibility for delivering a high quality service and retains high quality staff.
Well-led	Communication The Provider will maintain and promote effective communication skills between Service users, their support networks and Staff and vice versa. Where the Service User has cognitive or sensory impairment or when an interpreter is required, the Provider will ensure that alternative methods of communication are made available.

The outcomes information will be captured through the contract monitoring process as outlined in Schedule 4, Quality Requirements.

3. Scope

3.1 Service Description and Pathway

The Services are commissioned by NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) for the care of Service Users who have been assessed as eligible for NHS Continuing Healthcare (CHC), including Fast Track, in accordance with the NHS National Framework for Continuing Healthcare.

3.2 NHS Continuing Healthcare

All care packages apply to a package of care that is arranged and funded solely by the NHS for people aged 18 years and older.

CHC patients will need to be assessed and meet the nationally determined CHC criteria. Ongoing eligibility is subject to regular review and assessment by the ICB's CHC service. Patients who meet CHC criteria have a 'primary health need' and typically have care needs that are complex, intense and unpredictable and therefore require care to be delivered by well trained staff who can provide a flexible and reliable service. Care packages may involve long term care or short term interventions and are tailored to meet individual need.

Patients who meet CHC Fast Track will have been determined by an appropriate professional to have a 'rapidly deteriorating condition and the condition may be entering the terminal phase'. The Fast Track pathway is designed to enable needs to be met to enable patients to die in their own home or in a care setting.

The Service Provider will be required to:

- Ensure all Service Users are case managed and have an individual person centred person centred care plan
- Ensure individual Care Home services are subject to ongoing review and performance management through an Individual Service Agreement
- Assessing the individuals on-going needs and responding to changes
- Provide nurse oversight/care coordinator seven days a week to the service for advice and guidance (fast track block contract only)

4. Referral and admission process

4.1 Pre-provision assessment

The mutual agreement of the NHS Standard Contract, signed by both the Commissioner and the Provider, must be in place before the following process can be undertaken. Prior to this, the Commissioner must assure themselves of the following:

- Have there been any financial concerns or issues raised regarding the Provider
- Have there been any safety concerns or issues raised
- What is the CQC rating and report on the Provider

4.2 Pre-requisites to Placement

Prior to the commencement of the Care Package, the Commissioner sends the Provider:

- a copy of the needs assessment
- a copy of an outline Care Plan where available
- care hours information; and
- a proposed care start date.

The Provider will then:

- conduct a Care Consultation by the Provider or a Trusted Assessor;
- confirm within 48 hours of receipt of the referral if the referral is accepted or not; and
- agree the care start date specified by the Commissioner (if the referral is accepted).

In some circumstances, the Commissioner may request a care package to commence within 24 hours. Upon receipt of these requests the Provider will confirm by telephone with the Commissioner that:

- the Services can commence within the required timeframe;
- Care Workers are available; and
- a Care Consultation can be undertaken by the Provider or a Trusted Assessor.
- Provide the Commissioner with clear rationale for not accepting a referral, expected to be due to unavailability of staff or lack of appropriately skilled staff only.

Where a Care Consultation cannot be undertaken prior to the commencement of care, initial visits will be carried out by Care Workers trained to undertake a Care Consultation and competent to provide the required care.

4.3 The Care Consultation

- includes a Risk Assessment;
- establishes the Service User's needs;
- captures Service User's preferences, to include call times and tasks; and
- informs a detailed Care Plan.

A qualified Provider representative or a Trusted Assessor will conduct the Care Consultation. The Care Consultation will be conducted with the Service User and the Service User's family and Carers as appropriate.

4.4 Referral acceptance

By accepting the referral, the Provider confirms that they can meet the Service User's needs. If the Provider cannot meet the Service User's needs, they must reject the referral. The Provider may also reject the referral in accordance with clauses within the NHS Contractual Service Conditions.

4.5 Care package agreement

The care package is agreed by the Commissioner and the Provider.

The final decision on the care package remains with the Commissioner. The decision will be informed by the Provider and the MDT where necessary.

4.6 Individual Placement Agreement

In principle, the price for delivery of the service is set out in the Individual Placement Agreement (IPA) completed by the Commissioner and Provider in advance of each individual placement and not in the service specification.

The IPA describes that care package that the Service User is receiving (and which agreed price therefore applies) or, if necessary, describe a bespoke package and price.

The IPA needs to be signed by both the Commissioner and the Service Provider within 48 hours of receipt. Should the Service Provider not sign and return the IIPA to the Commissioner, the Commissioner will assume that the Service Provider has accepted the conditions and will deliver the service as agreed within the IPA and within this Contract.

4.7 Fast Track Pre-care package assessment (block contract providers)

The Service Provider will not be expected to meet the service user prior to service commencement. The service user will have been approved for Fast Track by the ICB Fast Track End of Life Team who will have reviewed the individual's care and support needs. A care needs summary or care plan detailing the care provision required to commence the package of care will be shared with the Provider. The Provider is expected to commence services within 2 days of referral.

In exceptional circumstances the Provider will be requested to meet and assess the Service User prior to acceptance to the service. This will be at the discretion of the ICB Fast Track End of Life Team.

The Commissioner will be responsible for quality assurance reviews of the Service Provider and reserves the right to inspect and review the care package without prior notice.

4.8 CHC review

The Commissioner will ensure Service Users are reviewed for their ongoing eligibility for CHC at the latest three months after the first CHC assessment, and annually thereafter, in line with the National Framework. Service Providers must ensure that they are aware of the date of the next proposed CHC assessment. Service Users will be asked if they want their representatives to attend the CHC assessment and outcome discussion.

The Commissioner will ensure CHC Fast Track Service Users are reviewed for their ongoing eligibility within three months of eligibility.

If, as a result of the CHC assessment or Fast Track review the Service User no longer meets the eligibility criteria the Service User will be referred to the appropriate Local Authority for onward assessment and support.

5. Activity Upon Service Commencement

5.1 General

The Service Provider will provide a reliable, cost effective, patient focused service of high clinical quality for Service Users. The Service will cover a range of activities that will support the needs and required outcomes detailed in the Care Plan and/or Advanced Care Plan.

5.2 Personal accommodation

The Service Provider will:

- give Service Users their own designated single room unless the Service User requests otherwise with approval from the Commissioner;
- enable Service Users to have access to their room at any time and as often as they wish;
- have a call alarm system to enable Service Users to get help the system should be accessible to the needs of the individual i.e. blind or deaf Service Users;
- not move Service Users to alternative accommodation, without prior consent from the Service User and the Commissioner (except in an emergency); and have furniture and fittings (including equipment) appropriate for Service Users including those with physical disabilities, bariatric requirements, severe epilepsy or behavioural disturbances.

5.3 Visitors

The Service Provider will share their visiting guidelines with Service Users and any appropriate interested persons on admission.

Every Service User has the right to refuse to see a visitor; the Service Provider will support this decision and maintain a Service User visitor log.

5.4 Advocates

The Service Provider will:

- support Service User use of advocates as defined in CQC Fundamental Standards
- where appropriate ensure a suitably qualified independent advocate is available where an individual lacks capacity to make decisions
- ensure there is an independent advocate available where a conflict arises in the Service User's life and the Service User has no relatives or is particularly frail or vulnerable. In these instances the Service Provider will also notify the Commissioner
- inform any advocate representing a Service User of major changes in the Service User's life

5.5 Service Users' possessions

The Home will handle Service Users' money and valuables as per CQC Fundamental Standards.

5.6 Property

Service Users will be allowed, within reason, personal property (e.g. pictures, music systems, televisions, and computers) in their room. Service Users/their advocates will be responsible for the maintenance of these items.

Service Providers will have procedures in place for protecting and securing Service Users' possessions kept in their own rooms.

The Service Provider's public liability insurance will cover Service User's property for theft or damage. This will not apply if damage was caused by the Service User.

The Service User will under no circumstances be required to sign a waiver of liability.

When the Service User is discharged, as agreed with the Commissioner, the Service Provider will contact the Service User's next of kin/a named representative so they can collect the Service User's personal effects. Where no next of kin/named representative exists the Service Provider will contact the Commissioner, who will make the necessary arrangements.

5.7 Money

The Service Provider will recognise the Service User's right to conduct personal finances. In some cases personal finances will not be managed by the Service User, power of attorney or a Local Authority appointee. In these cases the Service Provider, in agreement with the Local Authority, may apply to the Court of Protection for the right to manage the Service User's personal finances. If granted, the Service Provider must notify CQC on inspection, the Local Authority and the Commissioner.

If the Service Provider is responsible for Service Users' finances, money must not be pooled across Service Users.

The Service User will be expected to pay for the following items (this list is not exhaustive):

- Cigarettes and tobacco
- Alcoholic beverages
- Newspapers and magazines, where specifically ordered by the Service User
- Clothing and other similar personal items
- Personal travel incurred at the Service User's request (excluding travel relating to the Service User's care needs)
- Hairdressing
- Optical services
- Dental services
- Chiropody
- Legal advice
- Holidays
- Social activities not provided by the Home
- Toiletries over and above those provided by the Home
- Personal computers

5.8 Care Planning

Upon service commencement the Service Provider will develop a Person centered Care Plan in conjunction with the Service User. This initial person centered care plan must be received by the commissioner within 28 days (7 days for all fast track service users) of the Service commencement.

The Person centered care plan and/or Advanced Person centered care plan must demonstrate Service Users' individual needs, and the actions required to meet those needs. Plans must be implemented and reviewed and recording maintained in a contemporaneous manner.

Wherever possible the Service User shall be given a copy of the Person centered care plan and/or Advanced Care in their preferred language.

The Service Provider must maintain a care record, which details, in English, all the care provided to a Service User to confirm that the Person centered care plan and/or Advanced Person centered care plan has been implemented. This record must be standardised and include, but not be limited to:

- the date and time care was provided;
- the type and frequency of care provided;
- observations which may be relevant to need; action to be taken and the name of the person responsible; and
- the signatures of the Staff members providing the care.

The Service Provider must review Service Users' Person centred care plans and/or Advanced Person centred care plans monthly (minimum) which must involve a formal review with the Service User and be updated as the Service User needs change.

Significant changes to the Person centred care plan and/or Advanced Person centred care plan that result in additional cost or reduced cost must be notified and agreed to and by the Commissioner.

All Care Plans should be made available to the Commissioner on request and any changes in the care plans should be shared with the Commissioner within 48 hours of completion.

The Service Provider must ensure the availability of a Medicines Administration Record, which details, in English, information about the Service User and any medicines they are currently prescribed. This record must show:

- The Service User's name, address and date of birth
- Any drug allergies
- A list of all the current medicines prescribed; including name, strength, dose and frequency
- The receipt of any medicines brought in or obtained for the Service User

6. Ongoing Care

The Service Provider will ensure regular assessment of the Service User on going needs in accordance with CQC Fundamental Standards.

The Service User, their advocate, the Commissioner or the Service Provider may request a review of the Service User's needs at any time. If there is a significant change in the Service Users' needs or if the requirements of the existing Care Plan are not being met the Service Provider will notify the Commissioner or delegated officer as soon as is reasonably practicable

The Service Provider will meet the requirements detailed in Table 1. The Service User will not have all of these needs but where they exist the Service Provider is expected to identify and meet the requirements.

In addition to the requirements detailed in Table 1 the service provider should ensure that plans are in place to prevent avoidable hospital admissions.

The Service Provider will refer Service Users to specialist care as appropriate.

Table 1: Service User needs and requirements of Service Provider (non-exhaustive)

Needs:	Requirements:
Behaviour • aggression, violence or passive non-aggressive behaviour • severe dis-inhibition • intractable noisiness or restlessness and/or wandering • resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance, but see note below) • severe fluctuations in mental state • extreme frustration associated with communication difficulties • inappropriate interference with others • identified high risk of suicide	✓ understanding what can potentially trigger behaviour that presents a risk for each person or to others ✓ having Staff with the skills and knowledge to be able to respond immediately to reduce the likelihood of this behaviour happening or recurring
Cognition • marked short term memory issues • long term memory problems • disorientation to time and place limited awareness of basic needs and risks • difficulty making basic decisions • dependant on others to anticipate basic needs	✓ encourage Service User's family/friends to visit and bring in Service User's personal possessions (for instance, photographs) ✓ use reality orientation and validation techniques. ✓ have a communication strategy to assist Service Users to express needs and make decisions
Psychological and Emotional needs • unable to express their psychological/emotional needs • mood disturbance • hallucinations • anxiety • periods of distress • withdrawn from attempts to engage in daily activities	✓ assess, plan and deliver person-centred care ✓ prompts to motivate towards engagement with daily activities ✓ provide additional support to facilitate Service User involvement as required ✓ support Service User with life changing events ✓ recognise Service User depression and its effects on behaviour ✓ refer Service User to primary and acute care services ✓ staff must be skilled to recognise psychological and emotional problems and refer to appropriate services ✓ support Service Users' relationships (including partners, families and friends) ✓ have an activity programme tailored to meet the Service User's needs and prevent isolation
Communication (relates to difficulty with expression and understanding, not with the interpretation of language) • sometimes unable to reliably communicate	

• unable to express needs, even when assisted	✓ special assistance may be needed to ensure accurate interpretation of needs ✓ able to anticipate needs through non-verbal signs
Mobility • unable to consistently weight bear • completely unable to weight bear • high risk of falls • needs careful positioning • unable to assist or cooperate with transfers and/or repositioning • involuntary spasms or contractures	✓ have falls and moving and handling risk assessment and prevention strategies ✓ staff must be trained in moving and handling and falls prevention ✓ provide and maintain mobility equipment ✓ replace where necessary
Nutrition – food & drink • at risk of malnutrition, dehydration and aspiration • unintended weight loss or gain • Dysphagic • risk of choking • non-problematic/problematic tube feeding e.g. PEG • requirements for special diet for medical/cultural/religious reasons	✓ staff must have training on the use of nutritional screening tools and use appropriately and routinely according to recommendations ✓ seek GP/ dietician advice when a significant change in weight occurs or increase in 'MUST' score above 2 ✓ skilled intervention to ensure adequate nutrition/hydration and minimise risk of aspiration to maintain airway ✓ manage use of enteral tube feeds following specialist advice and seeking support as appropriate ✓ care for enteral tube +/- stoma site following specialist advice and seeking support as appropriate ✓ provide access to and assistance with (where required) nutritionally adequate diets for all Service Users, taking into account any special dietary requirements e.g. diabetes, texture modification ✓ provide access for all residents to nutritional complete menus that meet nutrition standards.
Continence • incontinent of urine and/or faeces • catheterised • requiring stoma care • chronic urinary tract infections	✓ recognise normal patterns and act on abnormal occurrences (seeking specialist advice as required) ✓ monitor for and act on any infection ✓ have appropriate management supervision and equipment (for instance, in relation to catheterisation, bowel management) ✓ have appropriate training in catheter and stoma care ✓ undertake continence assessments and promote continence with individual continence programmes
Skin (including tissue viability) - a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin.	✓ have policies and procedures that comply with current NICE guidance

• skin condition that requires monitoring or re-assessment • risk of skin breakdown requiring intervention • pressure damage or open wound • open wound, pressure ulcer with full thickness skin loss and narcosis extending to underlying bone • care of stoma site	✓ train Staff to promptly recognise and act on changes to risk factors as per CQC Fundamental Standards Regulation 18 and 19 ✓ have equipment to maintain skin integrity ✓ manage skin conditions ✓ care for enteral tube +/- stoma site (following specialist advice and seeking support as appropriate) ✓ have evidence-based wound management policy that meets local tissue viability referral criteria ✓ have a nominated tissue viability link nurse for each home who undertakes training in wound care to recognise problems as they occur and seek specialist advice
Breathing • shortness of breath which may require the use of inhalers or nebuliser • episodes of breathlessness that do not respond to management • requires low level oxygen therapy • requires CPAP (continuous positive airways pressure) • breathing independently through a tracheostomy • difficulty in breathing which requires suction to maintain airway	✓ staff must be trained to use equipment and oxygen to support Service User breathing as prescribed (for instance, nebulisers, CPAP and tracheostomy equipment)
Drug therapies and medication • requires prompting, supervision and assistance with administration • non-concordance with therapy or compliance issues • administration of complex medication • medication via enteral tube e.g. PEG • requires ongoing pain control EOLC (including Controlled Drugs) • reporting of adverse events, adverse drug reactions, incidents, errors and near misses	✓ monitor fluctuating conditions and managing side effects ✓ have a written procedure for medicine management which includes managing non-concordance and non-compliance ✓ ensure referrals for medication reviews at least every six months and/or as required ✓ use a range of methods to assess pain including a validated pain screen tool administer all medicines in accordance with a valid prescription and according to the directions on the pharmacy label ✓ administer analgesia as prescribed and monitor effect using pain assessment tool ✓ use non-pharmacological methods to reduce pain and discomfort ✓ manage medication for rapidly deteriorating or changing conditions ✓ have a system to prescribe (and store in the home) anticipatory end of life drugs ✓ staff must be trained in administering complex medication including via enteral tube e.g. PEG

	✓ access medications in most suitable format for administering via enteral tubes ✓ staff are trained in the use of syringe drivers
Altered states of consciousness – can include a range of conditions including stroke and epilepsy.	✓ undertake and regularly review risk assessments. ✓ implement individualised epilepsy management plans.
End of life care	✓ involve Service Users and their family/friends (as appropriate) in planning for their EOLC. ✓ act in accordance with a Do Not Attempt Resuscitation (DNAR) status if this has been recorded in the Service User's medical notes ✓ offer Advance Care Plans (ACPs) to Service Users at appropriate intervals. Review ACPs as required ✓ train all Staff in end of life identification, planning and coordination skills in line with a model such as the Gold Standards Framework ✓ manage Service User care in final days of life using evidenced based tools ✓ manage care in line with the "NICE quality standard for end of life for adults" ✓ develop links with community palliative care team

6.1 Interdependence with other services / providers

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 and community sector and independent providers.

The Service Provider must demonstrate how it will work with these other organisations to support Service Users and their carers to successfully manage the 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

6.2 Access to primary healthcare services

The Service Provider will ensure that Service Users have access to the full range of primary healthcare services, e.g. GP, Dentistry, Podiatry, Optician, Dietitian, and Pharmacy Services as per local referral criteria.

The Service Provider will ensure that Service User referrals are made in a timely manner and are followed up (including full documentation) when a referral is not accepted or actioned.

Primary healthcare providers are expected to deliver their services. If they do not provide the services this should be raised with the Commissioner who will work with primary healthcare providers and the Service Provider to resolve it.

6.3 Coordination with CQC and Local Authorities

Where possible the Commissioner will work with CQC, if applicable, and Local Authorities regarding contract monitoring and quality assurance to avoid duplication.

6.4 Equipment

The Service Provider will provide a full range of appropriate Equipment to meet the Service User's care needs and not make an additional charge for any Equipment required to meet the Service User's care needs. This includes standard bariatric equipment if required. For illustrative purposes, an example of the type of Equipment the Service Provider must provide is listed below. The Service Provider is required to ensure that the appropriate equipment is available to meet the Service User's needs. Service Providers should note that the list below is not exhaustive and shall not be limited to the items listed.

This list must be used in conjunction with the Essential Standards and requirements for equipment. The Service Provider shall comply with any updated requirements informed to it by any Commissioner or as set out in any guidance by a regulator.

If, following a clinical review it is identified that the Service User requires equipment not specified in the following list, the Service Provider must contact the Commissioner to discuss arrangements prior to purchase or supply.

Service Providers must ensure that equipment meets all legislative requirements.

The Service Provider will ensure that equipment is subject to regular monitoring and safety checks and maintenance/replacement as necessary and evidenced if requested by the Commissioner.

The Service Provider shall ensure that insurance cover is in place sufficient to cover the full replacement value of any loaned equipment damaged or lost and where sufficient insurance is not in place the Service Provider shall be liable for any deficit in the event of a claim.

The Service Provider shall ensure that any items loaned to the Service Provider from NHS Community Equipment suppliers are returned to the equipment provider immediately once the Service User no longer requires the relevant Equipment, by the specified due dates, or upon the reasonable request of the Commissioner.

Table 2: Minimum standard equipment to be provided by the Service Provider

Category:	Equipment:
Moving and Handling	• Height-adjustable profiling beds • Bed-rails and bumpers (where an assessed need is identified) • Over-bed trolley table • Hoist – sling, standing • Slings – one pair per Service User • Hoist scales • Slide sheets – one per Service User • Handling belt • Bath equipment – bath hoist, shower chair • sliding boards • turn tables

	• rota stand
Mobility	• Transit wheelchairs • Standards walking sticks and adjustable frames for occasional use • Grab rails
Seating	• Variety of chairs to meet individual needs and promote Service User independence
Skin	• Mattress – soft foam, medium overlay and low air loss mattresses (up to grade four) • Cushions – pressure relieving
Elimination	• Commode/commode chair • Bed pans • Urinals • Raised toilet seats • Stoma Bags, wipes and skincare products • Catheters • Catheter Care including tube and bag • Disposable gloves and aprons • Disposable wipes and tissues and other cleaning materials (e.g. hand gel) • Protective glasses • Access to incontinence products appropriate to Service User

Respiratory Support	• Nebulisers
	  ○ Filters
	  ○ Mask and tubing
	• Suction machines
	  ○ Liners
	  ○ Tubing
	• Catheters (Yanker)
	• Oxygen mask and tubing
	• Basic resuscitation trolley

Assistive technology	• Communication aids/signs to assist Service Users with hearing / visual / cognitive impairments • Call systems with an accessible alarm • Bed sensors where a need is identified • Tap/bath/shower sensors where a need is identified • Phone/door flashing lights if appropriate • Door alarms
Nutrition – food and drink	• Adaptive cutlery, crockery and drinking aids • Non-slip mats

Nursing Care	• Syringe drivers, sub-cutaneous sets and dressings • Blood glucose monitors • Body spillage kits • Weighing scales

6.5 Clinical governance

The Service Provider will:

- Work with the Commissioner to establish systems and procedures of clinical governance which would include participating in performance management processes and audits to promote continuous improvement in the quality of care services and to safeguard high standards of care by creating an environment in which care will continually develop. For the avoidance of doubt, the Service Provider agrees that the Commissioner has the right to audit at any time by giving 24 hours' notice to the Service Provider;
- Allow the Commissioner or any representative of a Commissioner to enter and to inspect the Services being provided at any time without notice. The Service Provider shall ensure that all Staff provide full co-operation to a Commissioner or relevant representative and shall provide access to all relevant documentation regarding the provision of the Service. In the event that the Commissioner considers that there are deficiencies in the Service then it may issue a Performance Notice which identifies the deficiencies and sets out an action plan for remedy.
- Participate and cooperate with the Commissioner on all investigations.
- Undertake and complete agreed actions where the Commissioner has provided an action plan or suggestions for improved performance.
- Participate in the re-measuring and re-auditing of performance management issues.
- Maintain a care record, which details, in English, a contemporaneous ongoing evaluation of the Service User's current care plans as detailed in Section 3.4. The Care Plan must be in a format that is accessible to the Service User family/carers.
- Ensure that a signatory register is maintained which includes the names and signatures of all staff involved in the provision of care.

6.6 Whole system relationships

The Service cannot work in isolation of other commissioned health services and the Service Provider will work co-operatively with the following:

- Hospital Discharge Liaison Team
- The Commissioner's CHC Assessment Team
- The Commissioner's District Nursing Teams; specialist nurses such as diabetes, respiratory, tissue viability, continence advisors and Palliative Care Services
- Specialist Nurses e.g. nutrition
- General Practitioners
- Allied health professionals such as Physiotherapists; Speech and Language Therapists; Dietitians; Pharmacists; Occupational Therapists; Podiatrists
- Social Care

- Voluntary sector
- Ambulance/Patient Transport Services
- Forensic Services

6.7 Safeguarding

The Service Provider will adhere to local up to date safeguarding polices and relevant procedures, and will have in place an active training plan for staff, ensuring that all clinical and managerial staff receive training in Adult Safeguarding and the Mental Capacity Act.

The Service Provider will ensure staff understand and apply the Deprivation of Liberty (DoLs) safeguarding in practice.

The Service Provider will operate a safe recruitment policy and procedure, and all staff in contact with Service Users having a full DBS check in full, disclosure and barring service (DBS).

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 the Commissioner at the same time.

6.8 Challenging Behaviour

Challenging behaviour must be considered in the context of the environment in which it occurs, the way the Service is organised and the needs of the Service User.

People who present with behavioural challenges can and should be supported to engage in activities that promote optimum quality of life and with support that ensures protection of their human rights. They should not be subject to inappropriate, punitive or harmful restrictions, ineffective treatments or unjustified and excessive use of medication.

The Service Provider must have a policy to positively engage and support Service Users who demonstrate challenging behaviour which take account of all relevant legislation, guidance and good practice.

Continuing behaviour of a disruptive nature will require a consistent response by staff. The Service Provider must be aware of and have plans for known challenging behaviour in the Service User's Person centred care plan.

- Challenging behaviour' is a socially determined construct. Positive Behavioural Support approaches should provide a basis for focussed assessment, formulation and interventions on the relationship between the individual and their environment, rather than on the elimination of behaviours.

- The Service Provider will deliver effective and safe support of people who present with behaviours that challenge services.

- Service Providers should work with the individual, families, professionals and other community resources to deliver interventions and support.

- Interventions will be delivered as part of an agreed multi professional care and treatment approach and must be based on a clear, comprehensive and agreed support plan.

Priority outcome measures for interventions should focus on quality of life and the protection of human rights. The use of restraint, as a last resort, must be in accordance with the Mental Capacity Act 2005, its amendment, The Deprivation of Liberty Safeguards and CQC Guidance. Staff responsible for the management of challenging behaviour and the use of restraint must be appropriately trained and work to the individual services' agreed operational guidelines to maintain best practice in relation to control and restraint.

The Service Provider will work with the Commissioner to take all reasonable steps to resolve issues as and when they arise. Termination will only occur if all other demonstrable efforts to resolve issues have been unsuccessful. All reasonable endeavours will be undertaken to mitigate a Service User's termination of the care package.

If, despite all reasonable endeavours to resolve issues the Service Provider wishes to terminate an individual care provision agreement, it shall do so in accordance with the provision of this contract. On receipt of the notice of termination the Commissioner shall use reasonable endeavours to arrange for an alternative placement for the Service User within the 28 days. However, where the Commissioner has not reasonably been able to transfer the Service User within 28 days, then the Individual Placement Agreement shall not be terminated until the Commissioner has arranged an alternative placement and moved the Service User to that placement. In the instance of behaviours displayed by the Service User as causing safety risks then the Service Provider and the Commissioner may agree an eviction notice of less than 28 days where an alternative placement can be sourced within that period. The Commissioner may also agree a level of enhanced support as an interim measure to maintain the safety of the Service User and staff.

6.9 Unplanned absence

If a Service User does not return as planned following agreed leave, the Service Provider will try to contact the Service User and those accompanying them to establish if there is a problem. If the Service User cannot be contacted, the Service Provider should instigate escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert.

If the Service User leaves the home/placement without notifying the Service Provider, the Service Provider should instigate escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert.

The Service Provider will notify the Commissioner of the unplanned absence within one working day.

The Service Provider will adhere to the reporting requirement for Service Users receiving care under any section of the Mental Health Act as appropriate.

The Service Provider will hold the Service User's room for a period of seven days which the Commissioner will fund. If the Service User does not return within seven days the individual placement will cease unless the Commissioner and Service Provider negotiate an extended retention period.

6.10 Access to NHS secondary and tertiary care services

6.10.1 Transport

The Service Provider will arrange transport for Service Users attending secondary and tertiary care service appointments. The Service Provider should liaise with the appointment provider

regarding return transportation. The cost of transport for NHS-related appointments will be funded by the NHS. For non-NHS related appointments the cost of transport will not be funded by the NHS.

6.10.2 Accompaniment/Escort

The Service Provider will ensure the Service User is accompanied appropriately to the level of risk and care need associated with the appointment.

The first four hours of escorting will not be charged as an additional cost to the Commissioner. Provider escorting required beyond the first four hours will be charged at the hourly rate agreed by the Commissioner.

In the case of hospital admission, the Service User will remain accompanied up until the point of admission.

6.10.3 Communication

The Service Provider will alert the appointment provider of any Service User interpretation and communication requirements prior to the appointment.

6.10.4 General principles

The Service User's placement with the Service Provider will remain open to the Service User for a period of six consecutive weeks.

The Commissioner may negotiate the extension of the Service User's placement longer than the standard six week retention period as required.

6.10.5 Activity supporting Service User admission into hospital

Upon admission into hospital or another provider the Service Provider will inform:

- the Service User's next of kin/ a named representative as soon as possible
- the Commissioner verbally and via email/letter within 24 hours
- the Service User's GP within 24 hours

The Service Provider will maintain contact with the hospital throughout the Service User's stay and be involved where necessary in discharge planning processes**.**

6.10.6 Activity supporting existing Service User discharge from hospital

Prior to the Service User's discharge from hospital the Service Provider will review the Service User's clinical needs to ensure they can be met by the Service Provider. This review should be carried out within the timescales stipulated in the Quality Schedule.

If the Service Provider can continue to meet the Service User's needs, upon re-admission to the Home the Service Provider will inform:

- the Service User's next of kin/ a named representative of the re-admission as soon as possible
- the Commissioner of the re-admission verbally/email/in writing within 24 hours
- the Commissioner of any revisions to the Care Plan within 48 hours of re-admission

In exceptional circumstances where the Service Provider can no longer meet the clinical needs of the Service User, the Service Provider will notify the Commissioner as soon as possible explaining the rationale for no longer being able to care for the Service User.

6.10.7 Activity supporting new Service Users' discharge from hospital

The Service Provider will assess new potential Service User's clinical needs to ensure they can be met by the Service Provider. This review should be carried out within the timescales stipulated in the Quality Schedule.

If the Service Provider can meet the Service User's needs, prior to admission to the Home the Service Provider will inform:

- the Service User's next of kin/ a named representative of the admission as soon as possible
- the Commissioner of the admission verbally/email/in writing within 24 hours
- the Commissioner of any revisions to the Care Plan within 48 hours of admission

To aide safe discharges, for each discharge from hospital to the Service Provider, the Service Provider shall complete a Transfer of Care Document provided in Schedule 2 J. A copy of this should be kept in the patient's file.

6.11 Service User Death

Service User deaths fall into three (3) categories: expected death, sudden unexpected death and suspicious death. The Service Provider will comply with NHS Standard Contract Service Conditions and the CQC Fundamental Standards and take into account any cultural requirements in relation to death of a Service User and any arrangements required.

For expected deaths the Service Provider shall:

- notify the Service User's next of kin/a named representative as soon as is reasonably practicable, so that suitable arrangements (including burial/cremation) can be made
- contact the Service User's GP and ensure that an appropriate doctor certifies the death immediately
- notify the Commissioner verbally within twenty-four (24) hours of the death
- confirm the verbal notification to the Commissioner in writing within forty-eight (48) hours of the death

For sudden unexpected deaths the Service Provider shall:

- notify the Service User's next of kin/a named representative as soon as is reasonably practicable
- contact the Service User's GP immediately and any other individual or organisation required by the GP; or where the Service User's GP cannot be contacted shall contact the police
- ensure that the Commissioner is notified verbally within twenty-four (24) hours of the death
- confirm the verbal notification to the Commissioner in writing within forty-eight (48) hours of the death

For all suspicious deaths the Service Provider shall:

- contact the Service User's GP and police immediately
- notify the Service User's next of kin/a named representative as soon as is reasonably practicable
- notify the Commissioner as soon as is reasonably practicable, and within one working day of the death
- confirm the notification in writing within 48 hours of the death

For suspicious deaths and sudden unexpected deaths where the GP and/or police need to attend the scene, the body will not be moved once death has been verified and the area will be vacated and left undisturbed.

The Service Provider will ensure that the Service User's medicines are managed in accordance with CQC Fundamental Standards and NICE guidance relating to medicines. The Service Provider will ensure that the Service User's medicines are retained for a period of seven (7) days in case there is a coroner's inquest.

7. Termination Processes

7.1 Termination of NHS Standard Contract

Except as provided below, the Commissioner on giving twenty-eight (28) days' Notice in writing may terminate the Care Home contract.

Except as provided below, the Service Provider may terminate the Continuing Healthcare Care Home contract by written notice which shall be no less than twenty-eight (28) days (unless the Commissioner otherwise agrees) and the Continuing Healthcare Care Home contract under no circumstances terminate until the Commissioner has (using its reasonable endeavours) located and transferred the Service Users to an alternative care provision.

Payment by the Commissioner to the Service Provider is made from the date of service commencement on a monthly basis for the duration of the project. If the Continuing Healthcare Care Home contract is terminated as a result of breach of this contract by the Service Provider payment will cease to be made on the day of service termination. The notice will give reasons why the care contract is being ended.

All Individual Placement Agreements will be terminated on termination of this Service Specification. No new Individual Placement Agreement contracts will be entered into if notice of termination of this Service Specification has been served.

In the event of termination of Care Home contract, the Commissioner and the Service Provider will work together in good faith to safeguard the interests of the Service User until such time as an alternative arrangement can be made.

7.2 Termination of Individual Placement Agreements

Except as provided below, the Commissioner on giving fourteen (14) days' Notice in writing may terminate an Individual Continuing Healthcare Care Home agreement.

The Service Provider may terminate the Individual Placement Agreement by written notice which shall be no less than fourteen (14) days' (unless the Commissioner otherwise agrees) and the Individual Placement Agreement shall under no circumstances terminate until the Commissioner has (using its reasonable endeavours) located and transferred the Service User to an alternative provider.

Should the Service User or the Service Users Representative wish to change providers, an agreement will be arranged with the current provider and the commissioner on the notice period. However in most cases, packages of care will end on the day before the new service starting, unless agreed otherwise by the commissioner

Should there be a death of a service user being supported as per 3.6 of this contract then the Individual Placement Agreement will end on the date of death. No further funding for that particular package of care will be provided to the Provider unless agreed otherwise in exceptional circumstances by the Commissioner.

The Commissioner may terminate the Continuing Healthcare Care Home contract with immediate effect, where it is agreed:

- Service User's needs can no longer be met or
- The care arrangement has broken down or
- Where there is potential for significant harm to Service Users

In cases where the Service User has become ineligible for financial assistance from the Commissioner, the Commissioner shall have the right to terminate the Individual Continuing Healthcare Care Home contract to the Service Provider as provided in the Individual Continuing Healthcare Care Home contract. The Service User will from this date take financial responsibility for their care package.

7.3 Termination of Block Contract Arrangements

Termination of Block Contract Arrangements should be agreed with the commissioner by a notice period of 3 months form the date in which the Provider or Commissioner gives notice.

The Commissioner and Provider should work together proactively to ensure continuity of care for the Service Users. The Provider may be asked by the Commissioner to work continue to support Service Users past the agreed notice period date.

Termination of a Block Contract Agreement does not terminate this Agreement. Should notice be given on the Service Specification then all Individual Care Provision Agreements will be terminated on termination of this Service Specification. No new Individual Care Provision Agreements will be entered into if notice of termination of this Service Specification has been served.

However, if active discussions are proceeding with a prospective purchaser of the provider covered under this contract and the new proprietor intends entering into a contract, then consideration may be given by a Commissioner to continue making new care arrangements.

8. Location of Provider Premises

The Provider's Premises are located at:

[Insert name, address of service location]