

SCHEDULE 4 – SERVICE SPECIFICATION FOR CARE HOMES WITH AND WITHOUT NURSING SERVICES.

1. Introduction

1.1. This schedule sets out the Service Specification relating to the provision of placements in Care Homes With and Without Nursing for Birmingham City Council and the NHS Clinical Commissioning Groups in Birmingham (the Commissioners). It describes the service aims, outcomes and standards the Commissioners expect from a service when a service is commissioned and one or both of the Commissioners pays towards that placement. This Service Specification should be read in conjunction with the Flexible Contracting Arrangement terms and conditions and the applicable Individual Service Agreement and Support Plan.

1.2. The provision of Care Homes With and Without Nursing will be delivered in accordance with health and social care policy to all adults. This includes those with complex health needs, the presentation of behaviours that challenge services, mobility needs and physical disabilities; sensory impairment (including acquired brain injury); cognitive impairment; dementia, learning disabilities and/or autism; and mental health needs.

1.3 The Commissioners will expect the service to provide:

- a personalised and responsive service with all staff delivering care being aware of residents personal preferences & agreed outcomes
- care and support that enables the resident to do as much as possible for themselves
- a range of stimulation to meet the individuals needs and wishes
- activities that are meaningful for residents
- equality of opportunity
- choice and the fulfilment of personal ambitions
- protection, dignity and respect
- relationship maintenance
- the meeting of religious, cultural and spiritual needs and wishes
- prevention of hospital admission and / or facilitation of safe discharge

1.4 This will be achieved by enabling the resident to acquire, reacquire and maintain their own skills in line with their agreed outcomes so that they are able to achieve and maintain their potential in relation to physical, intellectual, emotional and social capacity. For the avoidance of doubt, the new 'principle of well-being' as defined within the Care Act 2014, recognises that everyone's needs are different and personal to them and assumes that the individual is best placed to judge their own wellbeing. The Commissioners believe this principle is relevant whatever a resident's age or complexity of need.

1.5 The provision of outcome based Services will require changes to working practices and we will support Providers to develop new methods of providing this way of working.

2. Service Aims

2.1 This document sets out a specification relating to the provision of Care Homes With and Without Nursing Services by Providers who are registered with the regulatory body to support people who require accommodation with personal and/or nursing care. This document describes the key features of the service being commissioned and should be read in conjunction with the Flexible Contracting Arrangement terms and conditions.

2.2 Service description

The Service will include, as a minimum, the following facilities:

- use of bedroom
- dayrooms / communal areas for example a dining area and gardens
- lighting and heating
- laundry
- all necessary personal and nursing care
- access to personal hygiene facilities
- meal facilities that meet the needs of residents

2.3 Care packages may involve long term care or short term/temporary interventions and should be tailored to meet individual need. The Provider shall deliver the Service as defined in 2.1, including, but not limited to:

- care and support on a 24 hours basis seven days a week in an environment that ensures the residents needs can be met
- if delivering healthcare, 24 hours a day on-site nursing
- ensuring all residents have an individualised care and support plan
- ensuring individual care packages are subject to ongoing review and performance management
- all meals and additional supplementary food or drinks (as appropriate)
- ensuring it uses the Accessible Information Standard (<https://www.england.nhs.uk/ourwork/accessibleinfo/>)

3. Service Outcomes

3.1 This Service Specification demonstrates the commitment of the Commissioners to work in partnership with Providers to ensure a robust focus on service delivery that achieves optimum outcomes for the resident, in line with the four quality statements (domains) in the Adult Social Care Outcomes Framework and the five NHS Domains.

3.2 The Service outcomes are:

- enhancing quality of life for people with care and support needs including people with long-term conditions to enable residents to retain their independence, identity and sense of value
- ensuring that people have a positive experience of care and support including end of life care
- helping people to recover from episodes of ill-health or following injury
- treating and caring for people in safe environment and protecting them from avoidable harm
- delaying and reducing the need for care and support
- preventing people from dying prematurely

- develop and maintain close links with the community to ensure that the home is a part of the local activities
- delivering care that is safe and that meets the required quality standards at all times

3.3 Each resident should have a care and support plan that is available to all staff delivering care, and that reflects individual outcomes to achieve the service outcomes. The domains and the care and support outcomes will be the standards with which the Commissioners will quality assure the services provided.

3.4 Eligible residents are likely to have a range of individual care and support needs relating to:

- a physical disability and/or restricted mobility
- frailty related to age
- dementia
- long term health conditions
- end of life
- a sensory impairment
- learning disabilities
- mental health needs
- acquired brain injury
- progressive neurological condition, such as motor neurone disease
- attention and conduct disorders
- the presentation of behaviours that can challenge services

This list is indicative and is not exhaustive.

3.5 Provider Support Plan

As a minimum therefore, the Provider Support Plan shall include and not be limited to:

- the desired outcomes identified by and with the resident
- the identified support needs of the resident and the associated tasks required to meet those needs
- how support should be delivered in accordance with the resident's wishes, needs, likes, dislikes, methods of communication, etc.
- how the service will support the resident to achieve their desired outcomes
- involvement of the resident's family, their circle of support and advocates as appropriate
- risk assessments and management/control measures
- links to health action planning
- all relevant manual handling, restraint agreements and behaviour management plans (as appropriate)
- medication support requirements (where residents are able to self-administer this should be clearly recorded and supported so that they can maintain their independence for as long as possible)
- the timescale for the achievement of any time-bounded outcomes
- regular review arrangements
- details of the partial or full achievement of outcomes
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3.6 Service Delivery

The Provider(s) will deliver the service in line with national legislative and regulatory requirements, CQC Essential Standards, best practice and any Commissioner quality standards relevant to this provision. A person centred, outcome based approach will underpin service delivery.

4. Resident Referral Pathway

4.1 Residents may be referred for an eligibility assessment for FNC (including incontinence assessment) via one of the following non-exhaustive routes:

- Birmingham City Council social care and / or housing
- NHS Birmingham Crosscity or South Central Clinical Commissioning Group
- Arden and Gem Commissioning Support Unit
- BCHC staff including district nurses, dieticians, physiotherapists, OTs
- Community Mental Health Teams
- Joint Commissioning Team for learning disability
- Coventry and Warwickshire Partnership Trust (including LD)
- Joint Commissioning Team for mental health
- Hospices
- Hospitals including consultants
- Providers within Care Homes With and Without Nursing
- GP
- Forward Thinking Birmingham (CAMHS)

4.2 Birmingham City Council will be responsible for undertaking the assessment of need, developing and coordinating the residents' individual care plan, for monitoring progress and for staying in regular contact with the resident and everyone involved. In line with national guidance the health needs-based assessment will determine eligibility to either FNC or CHC.

4.3 The Providers will be responsible for regularly reviewing a resident's health and well-being requirements and when a change in needs is identified, the appropriate referrals are actioned e.g. a request for or actual completion of a continuing healthcare checklist (if the Provider has been assessed and given trusted assessor status) or a request for a continence assessment / reassessment.

4.4 Currently referrals will not be accepted for clients under the age of 18, unless this is a planned transition (16+). This may change in line with national policy or guidance.

4.5 NHS funding for care is considered under the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised 2016 and any future revision)*. The purpose of the National Framework is to provide for fair and consistent access to NHS funding across England, regardless of location, so that individuals with equal needs should have an equal chance of getting their care funded by the NHS. Where an individual is found to be eligible for Continuing Healthcare funding their care needs will be funded by the NHS for the period of eligibility.

4.6 Registered nursing can involve many different aspects of care. It can include direct nursing tasks as well as the planning, supervision and monitoring of nursing

and healthcare tasks to meet individual needs. A resident will receive NHS Funded Nursing Care (FNC) if they have been assessed and are eligible and:

- are resident within a Care Home that is registered to provide nursing care
- do not qualify for NHS Continuing Healthcare but have been assessed as requiring the services of a registered nurse

4.7 In the delivery of the service the Provider will work closely with family, carers or representatives, the Commissioners, Continuing Healthcare Assessment teams, General Practitioners and other relevant professionals, for example, those involved in end of life care. (This list is indicative and is not exhaustive).

5. Service Standards

5.1 The Provider will:

5.1.1 Have a brochure / guide in appropriate formats as to the service provided, available for residents (or potential residents) of the Service, Carers and professionals involved in setting up a Service. Where audio or visual recording devices are in use e.g. CCTV, the Provider should ensure that a potential resident (or current if intending to install) or their representative is aware and has consented to its' use in communal or agreed areas. Where consent is not possible consideration for DoLS should be made prior to use of CCTV. (Refer to CQC website for further guidance). Use of audio and visual recording equipment should be in line with current guidance and legal responsibilities.

5.1.2 Be able to demonstrate that the care and support required by every resident has been discussed with them and has been written down. The care and support plan should be completed by the resident and a suitably qualified and / or experienced member of staff prior to and upon admission. Where involvement of the resident is not possible, for example due to capacity issues, the Provider will ensure the care and support plan has been completed with an appropriate representative or advocate such as NHS Community Services and that continuing use of a clinical assessment tool is included. The care and support plan should be added to according to changing needs and risks but, in addition to that identified in Section 3.5, is to include (this list is indicative and is not exhaustive):

- emotional and psychological and mental capacity
- mobility, falls and frailty including manual handling
- breathing
- behaviour, cognition and communication
- tissue viability
- VTE (Venous Thromboembolism)
- pain
- medication
- nutrition
- continence / incontinence
- washing and dressing and personal and oral hygiene
- cultural and religious

Where applicable additional assessments include:

- end of life care
- rehabilitation requirements following a period of ill health or hospital admission

- nursing home specific National Early Warning System (<https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news>)

5.1.3 Be able to demonstrate that the initial assessments have been reviewed monthly or more frequently if needs have changed. The assessments should be updated according to the changing needs of the resident. The Provider will be able to demonstrate escalation processes are in place that supports findings from any assessment.

5.1.4 As far as possible, employ a workforce whose composition is reflective of the local population and ensure that staffing levels and skills mix are appropriate to meet all individual resident's needs.

5.1.5 Meet the resident's assessed mental and physical health, social, personal and cultural needs as detailed within their support/care plan. This may include supporting all aspects of personal care needs and to work in conjunction with multi agency care programme approach that acknowledges and respects people's gender, sexual orientation, age, ability, race, religion, culture and lifestyle.

5.1.6 With reference to the Support Plan, produce a detailed plan in collaboration with the resident and family, of how they will meet assessed needs. This will include details of ongoing reviews. The support plan should aim to maximise residents' self-care abilities and independence by helping and encouraging people to do for themselves rather than having tasks done for them.

5.1.7 Provide social, recreational and occupational activities which enhance the quality of life of residents and encourage participation and maintain autonomy and relationships.

5.1.8 Have mechanisms for resident and family engagement in the running of the home.

5.1.9 Ensure that resident's live in a safe environment and all Infection, Prevention & Control Guidance and legislation is adhered to by meeting the requirements detailed in Prevention and Control of Infection in Care Homes (2014, and any revisions), Standards for Better Health, National Health Service Act 2006, Health and Safety legislation and any appropriate NICE guidelines regarding Infection, Prevention & Control (<http://www.nice.org.uk/>).

5.1.10 Promote service delivery by trained and competent staff that encourages a preventative approach and maintains health and well-being such as encouraging a healthy diet, participation, and daily communication using appropriate methods including offering access to interpreters as agreed in the support plan. This may involve the use of Champions in areas such as Dementia, Dignity and Respect, or Infection, Prevention & Control. Promote service delivery that supports and ensures nurses are compliant with the NMC code and revalidation requirements.

5.1.11 Support all residents to access primary care services to meet their health needs and ensure that residents are offered the opportunity to access preventative medications such as the annual flu vaccination.

5.1.12 Have a whistleblowing policy and procedure.

5.1.13 Ensure and evidence the resident's satisfaction with the service provided and demonstrate that good practice is celebrated and any issues are acted upon with an agreed outcome reached.

5.1.14 Recognise the intrinsic value of people, regardless of circumstances, by recognising their uniqueness and their personal needs and treating them with respect, in line with Department of Health 'Dignity in Care' policy and End of Life Guidelines, e.g. Gold Standard Framework (<http://www.goldstandardsframework.org.uk/>).

5.1.15 Protect the resident's legal rights, and that they have access to an advocate or other representatives if required. This includes applications for a deprivation of liberty (as defined within the Mental Capacity Act 2005 Code of Practice and the Deprivation of Liberty Safeguards Code of Practice), registration for the right to vote, the updating of any identity related documentation such as a passport or the ability to contact a solicitor or other representative to make a will or appoint a lasting power of attorney (LPA) and ensure that the resident or their representative has signed a consent form as detailed in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11.

5.1.16 Retain responsibility for appropriate resident's escort and supervision until the hospital admits or discharges the resident. When an admission to hospital is required the Provider will ensure that the hospital receives all the relevant information regarding the resident and maintain contact with the hospital throughout the resident's admission. Prior to the resident's discharge from hospital the Provider will review the resident's clinical needs to ensure they can be met by the Provider. In exceptional circumstances when the Provider can no longer meet the clinical needs of the resident, the Provider will notify the Social Worker as soon as possible justifying the rationale for no longer being able to care for the resident.

5.1.17 Upon hospital admission, discharge and / or readmission, the Provider will inform:

- the resident's next of kin / their representative as soon as possible
- the appropriate Commissioner verbally / via email within 24 hours and in writing within five days
- the resident's GP within 24 hours
- (if appropriate) the Commissioner, in writing, after admission
- (if appropriate) the Commissioner, of any revisions to the care and support plan
- where applicable, the date of death to the appropriate Commissioner

5.1.18 Following discharge, where appropriate, contribute to an agreed programme of rehabilitation designed to assist resident's to re-establish lost skills, maintain current skills, or develop new skills in personal care and reduce periods of isolation and potential neglect. This may include enabling resident's to assist with tasks around the home. Tasks must not be done for the resident solely in order to save time.

5.1.19 Have a proactive approach to the changing needs of residents due to deterioration in physical or mental health, challenging or forensic behaviour. The Provider, where possible, should be flexible enough to meet such need without the resident having to lose their Service. This may involve increasing support to a resident in periods of temporary variations or fluctuations in their lifestyle or circumstances.

5.1.20 Have access to clinical equipment and / or mobility aids to maximise independence and support safe care. All equipment is issued on loan and for a defined period by the assessing professional. The Provider will ensure that any clinical equipment provided for the resident is:

- managed safely and securely in line with current regulations including relevant training for staff
- operated in line with the manufacturer's instructions
- kept clean and decontaminated as per infection control policies and procedures. Where necessary, when items of equipment need to undergo specialist decontamination, the Commissioners will provide instructions to the Provider
- made available for maintenance by the Commissioners (maintenance will be managed by the Commissioner only), and
- only for use in relation to the named resident i.e. as per the name on the prescription

5.1.21 If the Provider identifies a potential requirement for clinical equipment to be provided by the Commissioner or nominated other, then the Provider will inform the Commissioner and request a review of need(s).

5.1.22 In the event of the resident's condition changing making the equipment no longer necessary or the loan period of the equipment expires, the Provider must advise the Commissioner or equipment loans service within 24 hours in order that arrangements can be made for the equipment's collection.

5.1.23 Encourage networks for carers, whether relatives or friends, and recognise the views of other family members.

5.1.24 Have a range of policies and procedures that comply with all national and local legislation and guidance and these are frequently reviewed. The Provider will make these available to staff through an on-going learning and development programme. The range of policies includes but is not limited to all aspects of support planning and risk assessment and should include a range of operational policies and procedures detailing how the Provider will deliver the service, comply with all legal duties and reporting requirements together with providing quality assurance to the Commissioners.

5.1.25 The Provider will inform the relevant Commissioner of any events which occur in the timeframes stipulated in Appendix B, Quality Requirements and Notifications. Failure to provide notification of the events specified will be considered a breach of contract. Notifiable events will be informed to the relevant person regardless of whether the Provider has any residents placed by the Commissioner(s) at the time of the event.

5.1.26 Where applicable, devise an exit strategy in conjunction with the statutory services for the resident to return to their own home, for example resettlement activities.

5.1.27 The Provider will maintain effective measures for monitoring the capacity and financial stability of the Service and report any issues to their Contract Manager within the appropriate Commissioning Authority.

6. Interdependencies

6.1 Contact with relevant services will vary according to the needs identified in each resident's care plan. However, it is vital that the Provider co-ordinates all relevant services and ensures good communication is maintained and works within the data protection policy of the Council and the CCGs. It is vitally important to ensure that the Service is integrated into the end of life care pathway.

6.2 The Provider will ensure that residents have access to the full range of primary healthcare services, e.g. GP, Dentistry, Podiatry, Optician, Nutrition, Chiropody, specialist nursing services including tissue viability, incontinence and district nursing. Travel to and from a required appointment for primary health care services will be accommodated by the Provider. Primary healthcare needs that require frequent health care checks must follow NHS guidance and must be accommodated at no cost to the resident by the Provider or the GP overseeing the care e.g. Diabetic management, such as chiropody care and retinopathy eye screening, as indicated in NICE guidance <https://www.nice.org.uk/guidance/ng28>

6.3 The Provider will ensure that resident referrals are made in a timely manner and are followed up when a referral is not accepted or actioned.

6.4 The Provider shall advise the Commissioner at any point that it appears that a resident may require an advocacy service, or an Independent Mental Capacity Advocate (IMCA). The Provider shall provide all reasonable assistance and cooperation to the advocacy service or IMCA appointed in respect of any resident including access to all information held in regard of that resident and access to that resident at all reasonable times.

7. Staffing Arrangements

7.1 Providers are required to ensure that all staff are trained and competent to ensure that service delivery remains effective and compliant with the level of service required. Providers should ensure that any training Provider can meet the standards required by the Commissioners. The Provider should maintain a log of all training received and to be received and one that is available for the Commissioners to view upon request.

7.2 The Provider will ensure that all staff recruited from 1st April 2015 onwards have an induction together with on-going training and development in accordance with the Care Certificate (http://www.skillsforhealth.org.uk/images/projects/care_certificate/Care%20Certificate%20Standards.pdf). The Care Certificate is based on 15 Standards that health and social care workers should adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the

confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

7.3 For existing staff recruited prior to this date, the Provider will ensure that all of the principles of the Care Certificate are reflected in their ongoing training and development.

7.4 The Provider will ensure that resources for training and development are made available. This will be through a planned approach and staff have a learning and development plan in place from the point of induction. Staff should be released to attend training as appropriate to their identified training requirements.

7.5 The Provider must be able to demonstrate that staff have access to additional training to enable them to meet the needs of residents. This may include, for example, training in relation to dementia, positive behavioural support, managing specific conditions or specific communication tools. Such training will be provided by accredited organisations and will be evidence based to reflect current specialist and social care and clinical guidance

7.6 The Provider must be able to demonstrate that staff are supported with continuous professional development with access to ongoing training and relevant qualifications available; and time allowed for take-up.

7.7 The Provider shall undertake a training needs analysis for all staff that is reviewed regularly and updated and formulated into staff personal development plans. This will feed into a monitored organisational training and development strategy and identifies when refresher training is required. The programme will enable a flexible response to individual learning needs.

7.8 The Provider will be able to demonstrate assessment of staff competency and performance management and documented evidence is available for inspection.

7.9 In services where qualified nurses and other healthcare professionals are employed, the Provider must ensure that professional registration is maintained and that individual staff are accountable to their professional body.

7.10 The Provider is required to register their establishment/organisation on the Skills for Care National Minimum Data Set (NMDS) and complete their worker records, so as to provide meaningful workforce data. This information should be reviewed and updated regularly, as a minimum, at least once every six months, in order to maintain the accuracy of the data available.

7.11 Details can be found on the Skills for Care Website, NMDS, www.nmds-sc-online.org.uk

8. Staffing Requirements

8.1 The Provider will ensure that the requirements of this Service Specification and any associated terms are met at all times and that continuity of service is maintained for residents.

8.2 The Provider will ensure that their service hours to staff hour ratio supports service continuity taking into account staff leave and sickness levels. Service continuity and staffing levels will support current services as well as potential new services.

8.3 The Provider will ensure that the service is headed by a CQC registered leader, who provides a role model of best practice to ensure that staff know what is expected of them and motivates them to deliver. The Provider will support the CQC registered leader through appropriate skills acquisition and supervision. The range of skills should include but not limited to:

- management of change including the needs of their organisation
- leadership and the ability to manage and support their workforce
- effective planning and delivery of commissioned intentions
- generic business skills
- financial skills
- co-ordination of outcomes-focused complex care and support packages that require inter-agency liaison

8.4 Additional guidance for a range of management skills can be found here:

www.skillsforcare.org.uk/cqcguide and here:

<http://www.skillsforcare.org.uk/Leadership-management/Registered-managers/Your-induction-qualification-and-training.aspx>

Additional information for training for post-registration qualified staff can be sought after discussion with the Health commissioner and each home should speak to their Health Commissioner Lead. Courses such as the 'Mentorship Course' and 'Fundamentals in Nursing' are available.

8.5 The Provider is responsible for safeguarding the health, safety and welfare of residents. They will take appropriate steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced staff appropriate to the needs of the residents and the volume of services being commissioned. In addition, the Provider will ensure that those left in charge of the service have the appropriate knowledge, skills and experience.

8.6 Staff will be supported through regular supervision, training, coaching and observation and competency checks. As part of the supervision process direct observations should be undertaken as well as an Annual Performance Appraisal (APR). The objectives identified in the staff APR should be reflective of the aims and objectives of the service. All supervision and APR should be underpinned by the Care Commitment.

8.7 Through ongoing supervision, resident assessments and feedback, the Provider will ensure that:

- staff competence is reviewed regularly
- staff are encouraged to develop their skills, including any specific training necessary to meet the needs of the residents
- all staff to demonstrate an understanding of and commitment to delivery of outcome focused care to each resident

8.8 The Provider will ensure that staff are able to manage risk, with confidence in their ability to strike a balance between protecting those in vulnerable situations and supporting residents to determine and achieve identified outcomes.

8.9 The Provider will ensure that the Registered Manager receives appropriate support / development / guidance both formally through regular supervision and performance appraisal and informally with regard to all aspects of their role.

9. Registered Nurse

9.1 All clinical staff should be aware of and guided by their professional responsibilities to those they care for, as set out in their relevant code of conduct and by the registering authority, the Nursing and Midwifery Council (NMC).

9.2 The Provider will have a process in place to support nurse revalidation with all nurses having an identified confirmer. The Provider must have an identified clinical lead. Staff will be supported by a clinical supervision policy and programme.

9.3 In services where qualified nurses and other healthcare professionals are employed, the Provider must ensure that professional registration is maintained with annual checks and that individual staff are accountable to their professional body.

9.4 The Provider will ensure that all registered nurses within their employment understand their responsibility to:

- assess nursing needs on an on-going basis
- plan nursing care provision to meet the assessed need
- monitor care plans to ensure they meet resident 's needs, are sufficiently detailed and are reviewed and revised on a monthly basis (at a minimum) or when a change in need is identified
- implement the nursing care either directly or indirectly with an appropriate level of supervision and competency checking e.g. medication. This may be through delegation of tasks specific to each patient and should be conducted in line with Accountability and Delegation: What you Need to Know – Intercollegiate Document, Royal College of Nursing (2011)
- ensure that care staff, such as health care assistants, are alerted to changes in Care Plans in order that resident needs are appropriately met, and
- ensure timely referrals are made to other health professionals such as the GP or specialist nurse / therapist. this responsibility will also include:
 - ensuring referrals are to NHS health professionals where possible, unless expressly agreed with the Commissioner
 - following up or escalating concerns to a senior clinician, in a timeframe guided by resident need, when a referral has not been accepted or actioned
 - clearly documenting communications with health colleagues when circumstances arise in which resident 's needs are at-risk of being unmet, and
 - alerting the Commissioner in instances when escalation requests do not succeed and the resident is placed at increased risk

10. Indicative Staffing Ratio

10.1 The level of staffing will depend on assessed level of residents need within the home at any one time. The Provider will be expected to complete a dependency tool / care needs matrix in order to ensure resident's needs are being met appropriately. The Commissioners reserve the right to challenge the Provider if it is identified that the needs of residents are not being met.

11. Record keeping

11.1 The Provider will ensure that all staff comply with all applicable statutory and legal obligations concerning information recorded in relation to residents.

11.2 The Provider will have appropriate technology and a computerised database where records can be maintained safely and effectively.

11.3 The Provider will have policies and procedures for making, maintaining and securing Resident records. The policies and procedures will detail the standards for recording client information, internal audit and quality monitoring, storage, archiving and destruction.

11.4 The Provider will maintain in the home adequate records including, but not limited to:

- health and social care support and clinical records (assessments, care needs support plan, risk assessment etc.) which if not recorded at the time but documented contemporaneously should be done within 24 hours of an 'event' in line with NMC Code 2015 guidance on record keeping
- records of pre-employment checks including DBS records
- resident risk assessments on clinical condition e.g. mobility and falls and a summary of key risks such as times when this may increase
- documentation to show that identified risks have been reduced and how this is measured and monitored to reduce recurrence
- incident and accident book
- resident's monies and valuables brought into the home
- control measures for hazards and assessment of risk that must be implemented after a serious incident while longer term solutions are organized
- any complaints received and how they was addressed / actions taken
- if a resident has epilepsy a separate risk assessment and epilepsy protocol must be completed

Staffing

- personnel employed and basis of employment (permanent/agency)
- staff turnover
- timesheets
- signature register
- clinical staff registration and revalidation status
- staff training records
- staff clinical supervision records

Medication

- a central register of prescribed drugs and medicines
- a medication profile for each resident and associated risks
- medication administered per resident (except those for self-administration)
- medicines that the resident stores and self-administers (following a risk assessment)
- a “controlled drugs (CD) register” for recording
- the receipt, administration and disposal of controlled drugs schedule 2, in a bound book with numbered pages
- the balance remaining for each product
- computerised CD records where used, should comply with guidelines from the registering authority
- all ‘as required medication’ (PRN) must be clearly documented on a PRN protocol that gives clear guidance to staff when to administer
- medication must not be given covertly (disguised in food) unless a Mental Capacity Assessment and Best Interests meeting has deemed it is in a resident’s best interests for the Provider to do so [covert administration of medication refers to the practice of administering prescribed medication in food and / or drinks without the knowledge or consent of the person receiving them. Details of the expected practice and a pro-forma assessment form can be obtained from the Commissioner. If you have any specific questions or queries about covert medication please contact the Commissioner or the Medication Management team at your respective Clinical Commissioning Group (CCG)]

Complaints

- nature of the complaint
- name and address of the resident
- name and address of the complainant, where different
- date and time the complaint was received
- details of the process taken to investigate the complaint
- details of the outcome including the time and date of resolution of the complaint
- details of any action taken on the basis of the complaint to prevent future occurrence or improve service delivery
- names of employees and their supervisors involved in the action complained about, as appropriate, and any associated outcomes.
- any organisational learning arising in a timely manner and be made available to the Commissioners upon request
- complaint records including information concerning the nature of each complaint and action taken by the Provider in each instance
- compliments, concerns, comments received by the Provider

Other

- daily activities organised by the home to be displayed, resident specific and wider home specific
- activity participation record to be maintained
- resident visitor log

- repairs and maintenance
- equipment check log
- summary of resident and their representative forums
- summary report and action plan for the top three suggested areas of improvement identified in resident and their representative satisfaction survey
- internal quality assurance record

12. Key information & Significant Events Reporting

12.1 The Provider will take immediate and appropriate action and report the situation to the relevant bodies in the event of any of the following:

- abuse or neglect (Safeguarding via ACAP)
- inability of the Provider to perform any aspects of the service (Commissioner)
- hospital admission (ACAP)
- service closure (Commissioner and CQC)
- a temporary move (Commissioner)
- lost or missing resident (ACAP, CQC and Police)
- serious illness/injury/accident (ACAP and CQC)
- death (ACAP and CQC)

12.2 In the event of a major incident where the on-going delivery of care to residents may be interrupted, the Provider will take appropriate action as outlined in their Business Continuity Plan, notify the appropriate Commissioner *and follow up in writing to the relevant Contract Monitoring Team within 48 hours*. Major incidents may include:

- fire
- flood
- disruption to power, heat and lighting
- infection outbreak
- major staffing disruptions
- severe weather

12.3 In addition to the requirements of the Core Terms and Conditions in respect of Safeguarding, the Provider is required to note on their safeguarding log any organisational learning. The log should be kept up to date, and be made available to the Commissioner upon request.

13. Information Governance

13.1 All organisations that have access to NHS patient data must demonstrate that they are working towards use of the IG Toolkit to evidence practising good information governance, achieving and maintaining a satisfactory rating of level 2 in all requirements. If a Provider has FNC residents, they must demonstrate compliance with the legal rules and guidance when handling and sharing patient identifiable information.

13.2 Care Homes With and Without Nursing complete the IG Toolkit for one or two purposes:

- to provide IG assurances to the Department of Health or to the Commissioners, often linked to contractual obligations

- to provide IG assurances to HSCIC as part of the terms and conditions of using national systems and services including N3, E-Referrals, and NHS Mail etc.

13.3 How to register with the IG Toolkit website:

- follow the steps in the 'How to Register on the IG Toolkit' help guide at: <https://www.igt.hscic.gov.uk/resources/UserGuide-HowToRegister.pdf>
- Care Homes With and Without Nursing should be registered for the 'Voluntary Sector' view of the IG Toolkit, unless they are providing services under an 'Any Qualified Provider' contract

14. Quality Assurance

14.1 Quality

(http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf) is looking at a whole-system perspective, and reflects a concern for the outcomes achieved for residents and whole communities. The six areas or dimensions of quality assured are:

1. **effectiveness:** delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need
2. **efficient:** delivering health care in a manner which maximises resource use and avoids waste
3. **accessible:** delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need
4. **acceptable/patient-centered:** delivering health care which takes into account the preferences and aspirations of individual Service Users and the cultures of their communities
5. **equitable:** delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status
6. **safe:** delivering health care which minimises risks and harm to Service Users"

14.2 Some examples of clinical / quality care issues are (this list is not exhaustive):

- poor discharges
- falls
- Care Home acquired pressure ulcers
- medication errors
- concerns around nutrition and hydration
- poor personal care
- poor staff attitude

14.3 Any Provider who is commissioned to provide FNC placements will be required to complete the quality assurance processes for both Birmingham City Council and the health Commissioner(s).

14.4 Birmingham City Council has devised an Assurance Statement that a Provider is expected to complete six-monthly. The outcome of this process is then added to other information from:

- The Care Quality Commission (CQC)
- Performance data held by Birmingham City Council and the NHS
- Customer feedback from people using the services including feedback from Healthwatch Birmingham

14.5 The quality ratings help residents to understand the quality of service provided and look at the following factors:

- Giving people a good quality of life
- Helping people to be as independent as possible
- Involving people in the way care their care is provided
- Keeping people safe

14.7 All quality concerns and incidents will require the Provider to undertake an internal investigation which will be reviewed by the respective Commissioner as part of the quality assurance process. During this process a report on themes and trends will be expected from the Provider, on a quarterly basis, with related actions taken. The Provider will be expected to learn from the investigations undertaken as part of their own internal incident and investigation policies, providing feedback to the Commissioners within the themes and trends report.

14.8 The Commissioners reserve the right not to place residents if the outcome of the quality assurance process demonstrates a poor or inadequate rating or if any identified and actioned improvements cannot be sustained.

15. Safeguarding, Serious Incidents and Never Events

15.1 The Commissioners will expect the Provider to understand the difference between quality concerns and safeguarding, serious incidents and never events and to follow the appropriate actions for each including reporting routes.

15.2 Safeguarding concerns include (this list is indicative and is not exhaustive):

- physical abuse / hitting of patient by any party (including friends, family, visitors, staff)
- financial abuse or financial coercion of patient by any party
- sexual abuse/exploitation of patient by any party
- humiliation and degrading behaviour toward the patient by any party

These safeguards remain reportable through safeguarding routes as per safeguarding guidance on BSAB website <https://www.bsab.org>

16. Serious Incidents

16.1 Serious incidents are acts and / or omissions to act occurring as part of NHS-funded healthcare (including in the community) that result in:

- unexpected or avoidable death of one or more people
- unexpected or avoidable injury to one or more people that has resulted in serious harm
- unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent death or serious harm

- actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery
- an incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services
- major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation
- an incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services

17. Never Events

17.1 Never Events are serious, large preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare Providers. Some examples of a Never Event include (but not exhaustive):

- bedrail entrapment
- fall from a poorly restricted window
- wrong route administration of medication (topical, oral, IV, IM etc.)
- insulin overdose
- nasogastric tube misplacement
- scalding of resident

17.2 Any serious incidents and / or never event that has caused or is determined to have caused harm (as per the serious incident description in the agreed policy for Birmingham Care Homes with Nursing on the reporting of quality concerns, safeguards and serious incidents 2016 is reportable. Serious incidents and never events should be reported to the responsible CCGs inbox as listed below.

CCG	Inbox/Contact
Birmingham CrossCity CCG	bhamcrosscity.seriousincidents@nhs.net - SI inbox bccccg.qualitychc@nhs.net - Quality CHC inbox
Birmingham South Central CCG	Bsccg.seriousincidents@nhs.net
Sandwell CCG	sandwell.incidents@nhs.net
Solihull CCG	solihullccg.seriousincidents@nhs.net

17.3 Where there are any doubts about reporting an incident then guidance should be sought from the relevant Commissioner on a case-by-case basis.

18. Provider Payment (FNC element)

18.1 CQC registration requires 24 hour cover by a registered nurse in a Care Home With Nursing to meet the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

*“The intention of this regulation is to make sure that Providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. To meet the regulation, Providers **must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations.**”*

18.2 Where a resident has been assessed as eligible for FNC, the commissioning CCG will pay the nationally defined rate. The commissioning CCG will pay the Care Home direct for the FNC element of a package of care (health needs). This will apply where a resident is social care funded or self-funding and has also been assessed as eligible for FNC.

18.3 As the rate is nationally set, the CCG will pay that rate including any annual changes as defined by the Department of Health. Based on an assessment of continence, eligible residents may be entitled to an additional payment to cover the cost of continence products / disposables.

18.4 The FNC payment can be broken down as follows:

18.4.1 Direct Nursing Care

This is care provided on an individual basis to NHS FNC eligible residents, for example wound care, catheter care, monitoring, taking and recording observations, drug rounds, assisting residents with medication and preparing / decontaminating the drug trolley / equipment. This list is not exhaustive and may include diabetic monitoring, NGT / PEG feeding etc.

18.4.2 Indirect Nursing Care

These activities are for all residents in the Care Home With Nursing eligible for NHS FNC. These activities include:

- Planning, supervision and delegation time, for example delegating to and supervising the work of junior / unregistered staff, shift handover, giving clinical supervision and training
- Planning, supervision and delegation time for nursing staff taking into consideration any links to the career framework
- Care planning, liaising with other health / social care professionals, GP visits, liaising with relatives, ordering medication / prescriptions
- Logging training received, for example mandatory training, receiving clinical supervision, induction / orientation for temporary staff, monitoring and reviewing delegated skill competencies

18.4.3 Personal and Social Care

Activities identified as relating to personal and social care are excluded from the legal and policy framework definitions of nursing care provided by a registered nurse as services which need to be provided by a registered nurse. However, we recognise that nurses may typically carry out nursing duties concurrently with personal /social care duties where there is a specific medical reason for their intervention. An example of this would be where a nurse assists a resident to use the bathroom but with a view to monitoring their mobility or where the resident is at risk of seizure. Where this activity has been recorded as personal / social care rather

than direct nursing care for NHS FNC eligible residents, the nursing only element cannot be feasibly separated out and quantified.

The FNC set-rate has included an amount for personal / social care time to reflect the fact that this element of activity cannot be categorically separated from nursing care in view of the example of concurrent tasks described above and to reflect a registered nurses role in ensuring the overall wellbeing of a resident.

18.4.4 Management and Administration

This category of activity has been excluded from the calculation on the basis that following the legal and policy framework definitions, these activities do not need to be performed by a registered nurse.

Based on national guidance, the Commissioners would expect a minimum of 7 hours direct nursing care to be delivered per resident per week as part of the FNC payment. Tasks as detailed in 18.4.1 to 18.4.3 will be over and above this minimum number of hours (<https://www.gov.uk/government/news/nhs-funded-nursing-care-rate-for-2016-to-2017>).

18.4.5 Payment upon death of a resident (FNC element)

Following the death of a resident who is in receipt of FNC payment, the health Commissioner will cease payment on date of death, unless in exceptional circumstances and previously agreed by the Commissioner. This will include any payment made for continence products for that individual.

19. Third Party Top-Up / Third Party Funding Arrangements

19.1 Additional services are defined as those which the Service User would like to commission in addition to the commissioned social care and/or healthcare.

19.2 The Provider must ensure that the Service User and the care Provider have:

- discussed, and if agreed, have a written agreement that details services to meet personal lifestyle choices (wants)
- documentation relevant to the agreement signed by both Provider and the contributor
- mutually agreed to any proposed increase in third party contribution (details set out in clause 23.6.3 of the Flexible Contracting Arrangement)
- have discussed and understand that if a Service Users or contributors own funds cannot meet these additional personal lifestyle choices that the funding body will not be liable for their continuation
- with consent of the Service User, share the plan for lifestyle choice and details of the payment(s) with the relevant care managers

19.3 Provider will have a policy in place that clearly states how a 'top up' arrangement will meet best practice guidance from the outset.

19.4 Ensure that any transition in funding streams – social care to NHS and vice versa is documented and that any changes are notified to the Commissioner, residents and or family.

19.5 Ensure that any change in health and social care need is communicated to the NHS Commissioner, Social Worker, family and/or representative.

19.6 Third Party Top-Up / Third Party Funding Arrangements cannot be introduced part way through a placement.

19.7 Third Party Top-Up / Third Party Funding will only be paid by the Third Party Funder for the Service User's actual period of residence in the Care Home or Care Home with Nursing.

19.8 Where a Third Party Top-Up Price is agreed and the Third Party Funder makes the agreed contribution direct to the Provider, the Provider shall immediately notify the Council if the Third Party Funder defaults on any contributions for more than 4 weeks. In such cases, the Provider and Council will use their best efforts to reach agreement as to the pursuit of the debt and/or other actions to take.

20. Personal Budget

20.1 Following an assessment this is the amount of money determined as sufficient to meet the eligible care and support needs a person has. These are care and support needs not already being met in other ways (e.g. by a carer).

20.2 Once the amount is agreed planning on how to spend it can begin. The City Council will help by using experience to agree a plan which meets a person's care and support needs.

20.3 How can a personal budget be used?

There are a number of ways a personal budget can be used to meet unmet eligible care needs.

20.3.1 There is the option to take a Personal Budget as a Direct Payment. This will give the best possible choice and control over how care and support is met. Support and guidance on direct payments will be provided by the Council and anyone can speak to a Social Worker about this option.

20.3.2 The Council will arrange the services needed to meet unmet eligible care needs.

20.3.3 Alternatively, it is possible that the arrangements could be a combination of the above 2 options.

21. Health and Safety

21.1 There are two key pieces of legislation relating to Health and Safety in Care Homes. They are:

- Health and Safety at Work etc. Act 1974, and
- Management of Health and Safety at Work Regulations 1999

In 2014, the HSE reviewed and updated the first edition of the health and safety in care homes guidance and this is a good practice guide on ensuring that Care Homes With and Without Nursing comply with the above two acts.

Since publication the Care Quality Commission (CQC) in England has become the lead investigator of incidents where residents have been harmed because of unsafe or poor quality care. The HSE intends to produce a third review of the guidance but for now, the Council and the Clinical Commissioning Groups, expect Providers to implement many of the good practice suggestions and comply with reporting requirements detailed within the second edition.

The guidance can be found here: <http://www.hse.gov.uk/pUbns/priced/hsg220.pdf>

In addition to complying with all relevant legislation and the requirements of the Core Terms and Conditions, the Provider must ensure that there are policies and procedures in place and staff adhere to those operational policies and procedures. This will include, as appropriate, but not be limited to:

- Health and Safety at Work Act 1974
- Health and Safety (First Aid) Regulations 1981
- Consumer Protection Act 1987
- Furniture and Furnishings (Fire) (Safety) Regulations 1988 (as amended in 1993) Electricity at Work Regulations 1989
- Management of Houses in Multiple Occupation Regulations 1990 (as amended 2006) and local HMO regulations
- Health and Safety (Display Screen Equipment) Regulations 1992
- Manual Handling Operations Regulations 1992 (as amended 2002)
- Electrical Equipment (Safety) Regulations 1994
- Plugs and Sockets etc. (Safety) Regulations 1994
- Disability Discrimination Act 1995 (as amended 2005)
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
- Food Safety (General Food Hygiene) Regulations 1995 (as amended 2005 and 2006)
- Health and Safety (Consultation with Employees) Regulations 1996
- Gas Safety (Installation and Use) Regulations 1998
- Provision and Use of Work Equipment Regulations 1998
- Employers' Liability (Compulsory Insurance) Regulations 1998
- Management of Health and Safety at Work Regulations 1999
- Control of Substances Hazardous to Health 2002
- Regulatory Reform (Fire Safety) Order 2005
- Control of Asbestos Regulations 2006
- Smoke-free (Premises and Enforcement) Regulations 2006
- Smoke-free (Exemptions and Vehicles) Regulations 2007
- Smoke-free (Signs) Regulations 2007
- Smoke-free (Vehicle Operators and Penalty Notices) Regulations 2007
- Construction (Design & Management) Regulations 2007
- Control of Asbestos Regulations 2012 (amendment to regulation 3(2) of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)

22. Policy and Procedures

22.1 In addition to complying with all relevant legislation and the requirements of the Core Terms and Conditions, the Provider must ensure that there are policies and procedures in place. The Provider must ensure staff adhere to those operational policies and procedures. Policies and procedures will include but not be limited to the following, dependent upon the type of service, its CQC registration and the client group(s):

- Accepting gifts
- Access to records
- Activities
- Asbestosis and asbestos
- Care and health planning including person centered plans
- Care Act 2014
- The Care Certificate
- Carrying out risk assessments
- Chemist Audit Inspections
- Child protection
- Clinical governance
- Communications
- Use of own car for business purposes
- Compliments, concerns, complaints and comments
- Contingency planning and emergencies / BCP
- Contractors and other visitor's policy
- CQC Inspections – announced and unannounced
- Death on site
- Diabetes management
- Dignity and respect including privacy
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Deprivation of Liberty Safeguards/Mental Capacity Act (DoLS / MCA)
- Domestic pets in care homes
- End of life care
- Falls management
- Finance including funding sources, auditing
- Fire evacuation
- Food hygiene
- Health and safety
- Human Rights Act
- Hydration and nutrition
- Incident and accident reporting including near misses
- Infection Control Hygiene Waste
- Information governance and data protection
- Key worker system
- Managers Inspections
- Managing and Handling residents finances
- Medication Management including Medication Errors Records.
- Medications
- Mental Health Act
- Missing Persons
- New workers – induction and training record

- No access to SU policy
- Ordering Medication / MARS Sheets.
- Peripatetic services such as podiatry, hairdressing, chiropody, mobile dentists
- Personal care
- Personalisation CQC inspections and standards
- Pressure ulcers – identification and what to do
- Quality assurance
- Recording visits from health professionals
- Recruitment including volunteers
- Reporting to National Patient Safety Association
- Safeguarding Vulnerable Adults
- Serious untoward incidents
- Resident engagement / consultation
- Resident finances
- Specialist long term condition management
- Tissue viability
- Tobacco and alcohol use
- Under 18's on site
- Use of / Calling emergency services
- Use of IT and other electronic media
- Use of social media
- Violence against staff including behaviour that challenges
- Visits from people under 18
- Water testing
- When new residents arrive / leave
- When taking residents off site
- Whistle Blowing Policy

22.2 Human Resources

- Annual leave / flexi / toil
- Carers
- Consulting with staff
- Data protection and information governance
- DDA / Equality and diversity and inclusion
- Dress code
- Employment
- Equal Opportunities /Race relations
- Lone working
- Maternity /Paternity leave
- Out of hours emergencies
- Sickness / absence
- Staff conduct
- Staff supervision and appraisals and Continuous Professional Development (CPD)
- Staff Training Records
- Temporary agency or bank staff
- Training
- Use of mobile and company phones
- Working time directive

22.3 Equality and Diversity

- Equal Pay Act 1970
- Sex Discrimination Act 1975
- Race Relations Act 1976 (as amended 2000 and 2003)
- Disability Discrimination Act 1995 (as amended 2005)
- Human Rights Act 1998
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion or Belief) Regulations 2003
- Gender Recognition Act 2004
- Civil Partnerships Act 2004
- Employment Equality (Sex Discrimination) Regulations 2005
- Equality Act 2006
- Race and Religious Hatred Act 2006
- Employment Equality (Age) Regulations 2006
- Equality Act 2010

23. Behaviour that challenges

23.1 Behaviour that challenges must be considered in the context of the environment in which it occurs, the way the Service is organised and the needs of the resident.

23.2 The Provider must have a policy to positively engage and support residents who show behaviours that challenge. This policy will take account of all relevant legislation and guidance and good practice.

23.3 Continuing behaviours that challenge of a disruptive nature will require a consistent response by staff. The Provider must be aware of and have plans for known behaviour that challenges in the resident's Care Plan.

23.4 It is not acceptable to use any form of restraint (unless this has been agreed by a MDT and it is clearly documented on the Positive Behavioural Support plan the conditions when restraint can be used), verbal abuse or isolation as punishment for behaviour that challenges.

23.5 The Provider shall take all reasonable endeavours to mitigate resident eviction from the home. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Eviction should only occur if all other demonstrable efforts to resolve issues have been unsuccessful.

23.6 Any resident who has behaviours that challenge must have a positive behavioural support plan, which promotes understanding, the context and meaning of behaviour to inform the development of supportive environments and skills that can enhance a resident's quality of life.

23.7 Any incident must be fully documented and include the antecedent, behaviour and consequence (ABC).

23.8 All incident forms must be audited by a suitably experienced manager to identify any triggers and patterns.

24. End of Life Care

24.1 The Provider will ensure that if a resident is on an end of life care pathway there are appropriate end of life care plans in place to which they have been consulted upon. This will include preferred place of death, Do Not Attempt Resuscitation (DNAR), nil by mouth medications and access to anticipatory medications.

24.2 The Provider will ensure that any end of life care plan includes:

- a record of who else to involve in the decision making (e.g. health professionals, next-of-kin, carer's)
- details of the resident's condition and treatment
- instructions for the resident's treatment in emergency situations
- confirmation if the resident's has any 'do not resuscitate' instructions in place
- a record of the resident's wishes with respect to place of care/death and decisions regarding their treatment
- confirmation that the patient's wishes have been shared with external organisations with the patient's consent (e.g. out of hours service, community nurses, secondary care consultants)
- preparation of carers and / or families end of life care expectations

24.3 The Provider will ensure that staff are trained in end of life care and that they use an appropriate framework such as the Gold Standard to deliver end of life care.

24.4 The Provider will engage community based services, as appropriate.

24.5 The Provider will refer to CHC team if eligible for CHC fast track funding.

24.6 For the avoidance of doubt this Service Specification uses the Medical Association and the Royal College of Nursing point of view in that a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) should only be issued after discussion with patients or their family. In England and Wales, Attempt Cardio-Pulmonary Resuscitation (CPR) is presumed in the event of a cardiac arrest unless a DNACPR is in place. If a person has capacity as defined under the Mental Capacity Act 2005, that person may decline resuscitation. However any exploratory and or confirmation of choice discussion should not be in reference to the issue of consent to resuscitation but instead should be about eliciting an explanation.

24.7 A person may also specify their wishes and / or devolve their decision-making to a proxy using an advance directive, which is commonly referred to as a 'Living Will'.

25. End of life care UK Medical Profession Guidelines

25.1 The UK medical profession has quite wide guidelines for circumstances in which a DNACPR may be issued:

- if a patient's condition is such that resuscitation is unlikely to succeed
- if a mentally competent patient has consistently stated or recorded the fact that he or she does not want to be resuscitated
- if there is advanced notice or a living will which says the patient does not want to be resuscitated

- if successful resuscitation would not be in the patient's best interest because it would lead to a poor quality of life

In the UK, NHS Trusts must ensure:

- an agreed resuscitation policy that respects patients' rights is in place
- a non-executive director is identified to oversee implementation of policy
- the policy is readily available to patients, families and carers
- the policy is put under audit and regularly monitored

26. Best Practice Guidance

26.1 The Provider's policy for medicines administration will include:

- procedures to ensure that residents are able to take responsibility for their own medication if they wish
- methods for appropriate medication administration
- safe handling and administration of medication(s)
- reference to the controlled drugs procedures as defined by the Misuse of Drugs Regulations 2015
- medication review periods
- where and when to seek advice e.g. pharmacist, out of hours
- monitoring timeframes for a change in resident's condition together with associated required actions
- a minimum of monthly medication audits
- staff actions required when medication errors occur
- how and when to order and administer anticipatory end of life drugs
- the management of homely remedies and seeking the agreement of a GP and pharmacist
- medication waste management including regulatory requirements for the disposal of medical waste including swabs, soiled dressings, incontinence pads, used needles, instruments and similar substances and materials

26.2 The Provider's policy and procedures for the receipt, recording, storage, handling, administration and disposal of medicines should be in accordance with:

- The Handling of Medicines in Social Care Settings by The Royal Pharmaceutical Society of Great Britain 2007 or subsequent revisions; and
- Professional advice documents from registration authorities and Care Standards, including The Administration of Medicines in Care Homes, Medicine Administration Records (MAR) In Care Homes and Domiciliary Care, and the Safe Management of Controlled Drugs in Care Homes or subsequent revisions.
- The NMC Code 2015 (<http://www.nmc.org.uk/standards/code>).

26.3 The Provider will support residents to access appropriate benefits, financial advice and assistance with personal budgeting whilst recognise and respect the resident's right to confidentially conduct their own financial affairs, unless the resident does not wish or lacks the capacity, to do so. For example, debt advice or payment of bills.

26.4 If the Provider is asked and accepts responsibility for a residents' monies day-to-day money, then the Provider must ensure that this is not pooled and appropriate records and receipts are kept when money is handled. Under no circumstances will

the Provider use the resident's day-to-day money to meet fees payable under this care specification. However residents will be expected to pay for the following items from their own finances where applicable:

- newspapers and magazines, where specifically ordered by the resident
- clothing and other similar personal items
- personal specific travel incurred at the resident's specific request (excluding travel that is connected with the resident's care needs)
- specific hairdressing which is not provided by the home
- opticians
- legal advice
- holidays
- social activities (outside of those provided by the Provider)
- toiletries
- cigarettes and tobacco
- alcoholic beverages, and
- personal computers

26.5 There will be certain long term conditions such as diabetes or if over 65 years old, where exemptions to the above will apply for example chiropody, dental and optical care or retinopathy screening. Voucher support should be sought where applicable for purchasing of glasses.

27. Business Continuity Management

27.1 Business Continuity Management (BCM) is about identifying those parts of an organisation that you can't afford to lose – such as information, premises, staff, clients – and planning how to maintain these, if an incident occurs. Any incident, large or small, whether it is natural, accidental or deliberate, can cause major disruption to an organisation.

27.2 BCM is an established part of the UK's preparations for managing risks faced by organisations, whether from internal system failures or external emergencies such as extreme weather, flooding, terrorism, or infectious diseases. The Civil Contingencies Act 2004 recognised its importance by requiring frontline responders to maintain internal BCM arrangements and local authorities to promote BCM to commercial and voluntary organisations.

27.3 A Business Continuity Plan is part of the management arrangements. A plan cannot be considered reliable until it has been tested and has demonstrated it can be effective. Exercising should involve validating the plan, rehearsing key staff and testing systems which are relied upon to deliver resilience.

The service should demonstrate all staff have been directed and taken up the opportunity to have the flu vaccination to ensure business continuity is maintained in the provision of a 24 hour 7 day service.

28. Insurance

28.1 The Flexible Contracting Arrangement stipulates the amount of Insurance required for Public Liability Insurance (including Loss or damage to Service Users' personal effects) and Employers liability insurance (including volunteers).

28.2 In addition to the above the Provider shall, for the duration of the Flexible Contracting Arrangement, maintain such insurances as are necessary to cover the liability of the Provider in any one instance in the respect of the performance of this schedule with regards to nursing activity, including but not limited to:

Professional Indemnity / Treatment Cover	To a minimum of £5,000,000
Negligence	To a minimum of £5,000,000

28.3 The Provider shall where requested by the Authorised Officer provide evidence of such insurance, policies and receipts for premiums paid.

28.4 The Provider shall be liable for all injuries to persons arising out of the provision of nursing activity included in this Agreement, and shall indemnify the Commissioner against all actions, claims, damages and reasonable expenses in regard thereto.

28.5 In the event of a claim each of the Provider and the Commissioner shall co-operate in the provision of information requested by the other, subject to Legislation. The Provider shall where reasonably requested by the Commissioner, support the Commissioner in any press and media enquiries.

29. DNACPR

29.1 The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing) published In 2014 revised Joint Guidance on ‘Decisions relating to resuscitation’ (Appendix B). This guidance (www.resus.org.uk/pages/dnacpr.htm), formerly known as the Joint Statement, reflects in significant part the impact of the Court of Appeal’s decision in *Tracey* - http://www.39essex.com/cop_cases/r-tracey-v-cambridge-university-hospitals-nhs-foundation-trust-ors - which, rightly or wrongly, was viewed by clinicians as significantly changing the approach to consultation in relation to the imposition of DNACPR notices.

Providers must keep up to date with changes occurring in relation to the DNACPR forms. The Resuscitation council will provide updates on the use of the new ReSPECT form and guidance on this and other changes will be available from <https://www.resus.org.uk/consultations/respect/> .

30. Nutrition Support

30.1 There are a number of guidelines available below to help you deliver the best possible nutritional care in the community. If you have any questions about these guidelines, please contact St Patrick's Centre for Community Health.

30.2 The Home Enteral Feeding Guidelines will be available for download soon, but in the meantime contact St Patrick's Centre for Community Health for a copy on 0121- 446 1131 . You can find a copy of the Enteral Feeding Approved Ancillaries List at <http://www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/links-and-resources/>

30.3 You can also find our Nutrition and COPD leaflet at <http://www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/links-and-resources/> If you would like to order copies of this leaflet please contact LG Davies on 0121 430 9000.

30.4 Advice on Prescribing Oral Nutritional Supplements for Alcohol and Substance Misusers can also be downloaded at <http://www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/links-and-resources/>

30.5 Information is also available on the following at <http://www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/links-and-resources/> in order to give ideas for boosting calorie intake for people who have a poor appetite or who are trying to gain weight.

- Food boosters
- Increase the Calories
- Nourishing Drinks
- Boosting the calories recipe adaptation ideas
- Milk Shape Recipe

30.6 The local 'MUST' flow charts and care plans can also be downloaded from the same webpage.

30.7 The principles of the 'THINK KIDNEY' initiative is to be implemented and information on this can be found here:

<https://www.england.nhs.uk/patientsafety/akiprogramme/> and <https://www.thinkkidneys.nhs.uk/>

APPENDIX A – SERVICE SPECIFICATION FOR REHABILITATION IN SUBSTANCE MISUSE SERVICE IN BED BASED SERVICES

This section details further service standards which are specific to residents receiving services for Substance Misuse.

Rehabilitation in Substance misuse - Therapeutic programmes
<u>Service standards</u>
<p>The Provider Must ensure that:</p> <ol style="list-style-type: none"> 1. Units should have policies on the action to take if residents bring illegal or forbidden substances into the placement to use, give or sell to others. 2. Drug and alcohol rehabilitation services are structured time limited therapeutic programmes aimed at enabling residents to regain and develop maximum independence in a therapeutic environment in order to return to independent living in their own home in the community. 3. The Council will Purchase therapeutic programmes that enable individuals who are dependent on drugs and / or alcohol to work towards long term abstinence and recovery. They can be delivered in residential Care Homes. . 4. Restrictions will be applied for therapeutic reasons to the formation of exclusive relationships between residents whilst undergoing substance misuse rehabilitation.

Rehabilitation in Substance misuse - Rehabilitation programmes
<u>Service standards</u>
<p>The Provider Must ensure that:</p> <ol style="list-style-type: none"> 5. All rehabilitation programmes address: <ul style="list-style-type: none"> • Education and awareness of the effects of problem substance misuse on the body; • Relapse prevention; • Alternatives to substance misuse; • Self-management of daily living skills such as personal hygiene, daily routines & time management, domestic skills including budgeting, shopping, cooking and housework, managing free time; • Relationships with others including rebuilding family relationships; • Personal skills, self-esteem, assertiveness skill; • Criminality and substance misuse; • Training, education and employment skills and needs; • Harm minimisation; • Continuity of Care; • Community Reintegration; and • House meetings to address residents issues as and when they arise, 6. The Council will also purchase rehabilitation programmes that are able to address parenting skills, other addictive behaviours, rough sleeping, dual diagnosis (of mental health problems),

Rehabilitation in Substance misuse - Rehabilitation programmes

and cultural needs. This would include programmes that would lead to vocational qualifications.

7. Substance misuse rehabilitation placements are always of a time-limited nature and permanent placements cannot be considered.

Rehabilitation in Substance misuse - Service Delivery

Service standards

The Provider must ensure that:

8. Prospective residents will be made aware of the type, range and standards of services available from a placement prior to their admission, including the restrictions in place to enable and address therapeutic needs. Whilst residents retain the right to leave a particular placement, they will be supported to stay and enabled to recognise that having difficulties with elements of a programme is part of the process of relapse prevention and moving towards abstinent recovery.
9. Residents are required prior to admission, to give their consent to the conditions and requirements of the regime that they select to undergo and thereby they agree to the restrictions imposed on their freedoms for therapeutic reasons.
10. The major input of 'personal care' is enabling, counselling and/or group-work rather than physical care.
11. The therapeutic plan of the provision is to provide residents with a structured day that they will be made aware of and agreed on admission. This will be person centred and reflect the individual resident. Placements should make the approach explicit in their brochures. The Provider will determine the timetable. As the programme progresses there will be some phased withdrawal of controls to plan and enable community re-integration. The nature and content of the treatment plan will also provide education on and make explicit that continuing /aftercare following placement is an integral part of the individual plan.
12. Residents have to agree to restrictions being put on contacts with their social networks such as visits, telephone contact and correspondence with people outside the Unit including family members, to enable them to engage in the structured programme and to gain maximum benefit from the placement alongside reducing risk and minimise the likelihood of relapse.
13. The Council will not purchase programmes of detoxification in the persons own home, nursing home or hospital. Such treatment is the responsibility of the National Health Service.
14. An overall programme of activities will be presented in a timetable form, covering at least 8 hours a day and 6 days a week. Activities will be itemised stating when they will occur and who will be responsible for their implementation. This timetable **will** include all activities that are part of the therapeutic programme including information sessions, counselling, group work, private time on assignments, free time and recreational periods that are designed to promote and build social skills, self-esteem and assertiveness.
15. It is expected that residents can expect a minimum of four hours of counselling a day, five days a week. This counselling will be provided in individual or group-work sessions.
16. Where residents have responsibilities towards dependent others particularly children, the maintenance and development of relationships must be considered in the individual treatment plan and timetable of the placement, in accordance with visiting times and therapeutic programme. Residents need to be made aware at assessment and in the Providers brochures that contact will be subject to the requirements of the regime they select to undergo. In circumstance where this is not appropriate the Care Manager will notify the Provider.

Rehabilitation in Substance misuse - Treatment Plan

Service standards

The Provider must ensure that:

17. A written agreement between the residents or their representative and the Provider must be in place alongside the treatment plan that covers issues such as:
 - Resident's rights.
 - Any limits to the denial of choices, privacy and human rights where this is essential for therapeutic reasons to change destructive behaviour patterns.
 - Unacceptable conduct and the circumstances under which a resident would be asked to leave.
 - Smoking policy.
 - Formation of exclusive relationships within the Provider unit.
 - Insurance of personal items.
 - Charges and how bills will be rendered and to whom.
 - Visitors and domestic arrangements.
 - Complaints procedures.
 - Handling of abuse between residents and between residents and staff.
18. Each resident will have a copy of their Treatment Plan and a written agreement covering the conditions of the placement.

Rehabilitation in Substance misuse - Discharge

Service standards

The Provider must ensure that:

19. Providers, the placing agency, and the resident act in partnership to ensure that discharge care arrangements exist that are relevant to the needs of the residents and are workable. Respective responsibilities of all involved are to be clear whether the discharge is planned or unplanned.
20. The Provider allocates a Key Worker who will be the link between the resident in the residential unit and the Care Coordinator in the community
21. Residents will not be in touch with these placement units on a long term or permanent basis, so it is crucial that the issue of leaving is addressed from the outset.
22. Discharge arrangements are the responsibility of The Council's Care Coordinator and there must be a clear agreement with the residents on where they will go on leaving their placement.
23. Discharge must ideally be a planned event and a system must be in place for informing the residents' Care Coordinator of the outcome of their placement including any potential breakdown or problems arising.
24. The Provider must send a Discharge Report to the Care Coordinator within 7 Working Days of discharge. This will include a progress report and what travel arrangements have been made.
25. The conditions under which an emergency discharge is required must be made clear in writing on admission.
26. Where there is an emergency discharge, the following arrangements will apply:
 - The Care Coordinator will be informed within one Working Day.
 - The Residents' family will be informed if they have any current involvement.
 - There must be an agreed form of transport back to the area of origin and arranged by the Provider.
 - There must be written statements of the conditions under which a resident may return to the treatment unit.

Rehabilitation in Substance misuse - Medication / Detoxification, Therapy and Specialist Support

Service standards

The Provider must ensure that:

27. A clear distinction is made between detoxification and any other medication programme. The management of a resident's medication is undertaken in a responsible and sensitive way allowing for self-medication where appropriate.
28. If there is a programme of detoxification treatment undertaken on site that requires medical or nursing support on a 24-hour basis, this should be provided in accordance with the Registered Homes Act 1984 Part ii.
29. Any medication programme in place must be overseen by a qualified and experienced medical practitioner with active nursing support as required under the Care Standard Act 2008.
30. Where a resident registers with a GP or dentist, the nature of the placement should be made known to the health practitioner to avoid opportunities for procurement of forbidden substances.
31. The assessment of risk to themselves and to others, of allowing a resident to retain and administer their own medication, should be done on admission and notified to the Care Manager. It should be recorded and regularly reviewed.
32. Where a resident requires treatment of a specialist nature that cannot be provided by the staff at the Unit, the Provider must liaise with the Care Manager and must arrange for these services to be provided locally.
33. Staff and volunteers, who have themselves had drug and/or alcohol dependency problems, must be able to demonstrate at least 2 years sobriety and stability in recovery. This does not apply where residents who have progressed through the programme and are used as Mentors for people newly engaged in the programme.
34. No more than 50% of staff will be comprised of people recovering from drug or alcohol dependency.
35. When specific treatment work is being undertaken such as individual or group counselling, there shall be two counsellors on the premises, one of whom can be someone in training.

Rehabilitation in Substance misuse - Additional requirements for residential units

Service standards

The Provider must ensure that:

36. Overnight arrangements must include a minimum of one member of staff on the premises and another member of staff to be available for emergencies. These arrangements apply equally to times including weekends when no specific counselling work is being undertaken. Residents must have access to a trained Counsellor 24 hours a day via an on call system.

Rehabilitation in Substance misuse - Privacy

Rehabilitation in Substance misuse - Privacy

Service standards

The Provider must ensure that:

37. All homes should have a policy on confidentiality and rights to privacy. However, the nature of substance misuse rehabilitation requires units to be free to search for evidence of compliance with the conditions of the placement especially substance misuse.
38. Limits may also need to be imposed on those who can be invited to the Unit and to a resident's room and the length of time that a resident can spend alone in their room.
39. It will not generally be appropriate to provide residents with lockable bedrooms or storage facilities until a risk assessment indicates otherwise.
40. A clearly designated and private area will be available for privacy during visits from family and the Care Manager.
41. Residents should only be offered single rooms when they have been assessed as able to comply with the Provider's conditions on substance use. Room sharing will therefore be acceptable especially in the early stages of a placement but only on a single gender basis. It must be clear to residents, the circumstances under which they can choose to be accommodated in a single room.

APPENDIX B – QUALITY REQUIREMENTS AND NOTIFICATIONS

The Provider will inform the relevant Commissioner of any events which occur in the timeframes stipulated in the table below. Failure to provide notification of the events specified will be considered a breach of contract by the Provider. Notifiable events will be informed to the relevant person regardless of whether the Provider has any Service Users placed by a Commissioner at the time of the Event.

Ref. number	Performance Indicator	Information to provide	Frequency	Notify Council	Notify CCG	Format of information	Identification of issue for escalation
N1	CQC reportable incidents	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N2	Change in CQC registration	Notification of change in care groups to be catered for	30 days prior to change taking effect	Yes	Yes	Email	N/A
N3	Change in home registered manager	Change in management of home details including any period when there is no manager	Within 7 days of occurrence	Yes	Yes	Email	N/A
N4	Investigations by CQC	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N5	Suspensions by CQC	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N6	RIDDOR reportable incidents	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met

Ref. number	Performance Indicator	Information to provide	Frequency	Notify Council	Notify CCG	Format of information	Identification of issue for escalation
N7	HSE improvement notices	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N8	Investigation by Local Authority or CCG	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N9	Suspension by Local Authority or CCG	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N10	Notification of Safeguarding of Vulnerable Adults alerts to BSAB	Description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N11	Serious incident including VTE, pressure sores, medication management	Notification if the GP and / or pharmacist or WMAS is contacted urgently regarding medication issues	Within 7 days of occurrence		Yes	By Phone and email	Reviewer decision
N12	Death of a Service User	Notification and reason	Within 24 hours of occurrence	Yes	Yes	Email	Reviewer decision
N13	Suspicious death of a Service User	Notification	Within 24 hours of occurrence	Yes	Yes	Email	Reviewer decision
N14	Hospitalisation of a Service User	Notification and reason	Within 48 hours of occurrence		Yes	Email	Reviewer decision
N15	Service User discharged from hospital back in to Provider's care	Notification	Within 48 hours of occurrence		Yes	Email	N/A

Ref. number	Performance Indicator	Information to provide	Frequency	Notify Council	Notify CCG	Format of information	Identification of issue for escalation
N16	Provider has assessed that they can no longer meet a funded Service User's needs on return from hospitalisation	Notification and reason	Within 24 hours of occurrence, following re-assessment		Yes	Email	N/A
N17	Potential serious risk is identified as part of a Service User's risk assessment	Notification and description	Within 24 hours of occurrence	Yes	Yes	Email	Reviewer decision
N18	Service User is in need of medical attention, but refuses to accept it	Notification and description	Within 24 hours of occurrence		Yes	Email	N/A
N19	Unplanned absence / absconsion of a Service User	Notification and description	Within 24 hours of occurrence	Yes	Yes	Email	Automatic if target not met
N20	Any report of 'lessons learnt' following safeguarding alerts, serious incidents or the presentation of high risk events	Report detailing steps taken to mitigate re-occurrence	Within 14 days of occurrence	Yes	Yes	Email	Reviewer decision
N21	Deprivation of liberty referral	Notification	Within 48 hours of occurrence	Yes		Email	Automatic if target not met

Ref. number	Performance Indicator	Information to provide	Frequency	Notify Council	Notify CCG	Format of information	Identification of issue for escalation
N22	When a referral to an independent advocate has been made by the Provider on the Service User's behalf	Notification	Within 7 days of occurrence	Yes	Yes	Email	N/A
N23	Infection Control	Infection Control Issues. for example Leigionella, Noro Virus, MRSA, C-Diff, Scabies or other contagious outbreaks.	Within 24 hours of occurrence		Yes	Email	Reviewer decision
N24	Tissue Viability (Prevalence data may be requested on an ad hoc basis)	Any pressure ulcer which is grade 2 and above. (grade, description, where acquired (e.g. hospital, care home) and confirmation that treatment plans are in place within 2 days)	Within 24 hours of occurrence		Yes	Email	Reviewer decision
N25	Clinical equipment provided by the Commissioner is no longer required by a Service User	Notification of clinical equipment no longer needed	Within 7 days of occurrence	Yes	Yes	Email	N/A
N26	Activation of a Business Continuity Plan	Notification and reason	Within 7 days of occurrence	Yes	Yes	Email	Reviewer decision

Ref. number	Performance Indicator	Information to provide	Frequency	Notify Council	Notify CCG	Format of information	Identification of issue for escalation
N27	Annual financial statements demonstrating a trading loss	Reasons for trading loss and any supporting documentation as requested by the Contracting Authority	Within 7 days of occurrence	Yes	Yes	Email	Reviewer decision
N28	Formal complaints not resolved within 1 month	Description of complaint, action taken to resolve and timeframes	Within 7 days of passing 1 month timeframe	Yes	Yes	Email	Automatic if target not met
N29	Initiation of legal proceedings against Provider	Description	Within 48 hours of occurrence	Yes	Yes	Email	Automatic if target not met