

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Not Applicable

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

This Schedule will be applicable, and should be included in full, where the Provider is to have a role in delivering the Enhanced Health in Care Homes care model in collaboration with local PCNs. If the Provider is not to have such a role, delete the text below and insert Not Applicable.

Indicative requirements marked YES are mandatory requirements for any Provider of community physical and mental health services which is to have a role in the delivery of the EHCH care model.

Indicative requirements marked YES/NO will be requirements for the Provider in question if so agreed locally – so delete as appropriate to indicate requirements which do or do not apply to the Provider.

1.0 Enhanced Health in Care Homes Requirements

1.1 Primary Care Networks and other providers with which the Provider must cooperate

[] PCN (acting through lead practice []/other)
 [] PCN (acting through lead practice []/other)
 [other providers]

1.2 Indicative requirements

Have in place a list of the care homes for which it is to have responsibility, agreed with the relevant ICB as applicable.	YES
Have in place a plan for how the service will operate, agreed with the relevant ICB(s) as applicable, PCN(s), care homes and other providers [listed above], and abide on an ongoing basis by its responsibilities under this plan.	YES
Have in place and maintain in operation in agreement with the relevant PCN(s) and other providers [listed above] a multidisciplinary team (MDT) to deliver relevant services to the care homes.	YES
Have in place and maintain in operation protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.	YES
Participate in and support 'home rounds' as agreed with the PCN as part of an MDT.	YES/NO
Operate, as agreed with the relevant PCNs, arrangements for the MDT to develop and refresh as required a Personalised Care and Support Plan with people living in care homes, with the expectation that all Personalised Care and Support Plans will be in digital form.	YES/NO
Through these arrangements, the MDT will:	

<ul style="list-style-type: none"> • aim for the plan to be developed and agreed with each new resident within seven Operational Days of admission to the home and within seven Operational Days of readmission following a hospital episode (unless there is good reason for a different timescale); • develop plans with the person and/or their carer; • base plans on the principles and domains of a comprehensive geriatric assessment including assessment of the physical, psychological, functional, social and environmental needs of the person including end of life care needs where appropriate; • draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and • make all reasonable efforts to support delivery of the plan. 		
<p>Work with the PCN to identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows.</p>	<p>YES/NO</p>	
<p>Work with the PCN to support discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27 (https://www.nice.org.uk/guidance/ng27).</p>	<p>YES/NO</p>	

1.3 Specific obligations

[To include details of care homes to be served]