SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

1.0 Enhanced Health in Care Homes Requirements

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

[Insert PCN Name] PCN (acting through lead practice **[Enter Lead Practice Here]**/other)

1.2 Indicative requirements

Have in place a list of the care homes for which it is to have responsibility, agreed with the relevant CCG/ICB as applicable.	YES
Have in place a plan for how the service will operate, agreed with the relevant CCG(s)/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
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 with effect from no later than 31 March 2023. Through these arrangements, the MDT will: • 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	YES

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.	
Work with the PCN to identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows.	YES
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).	NO

1.3 Specific obligations

[Enter Care Home Name]
[Enter Care Home Address]