Service Specification for Community Care Beds

A new specification for community intermediate care, background and context

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	1
Service	Community Intermediate Care Beds
Commissioner Lead	Sarah Lovell Associate Director
Provider Lead	

A new specification for community intermediate care, background and context

We are seeking to commission a CIC bed service for the city which offers a high quality experience for people by supporting them to achieve their independence and potential so that they can return to their own home as soon as possible. The service will empower people and build confidence by supporting them to set their own goals and by addressing their psychological and emotional needs as well as their health and social care needs. Every person working in the CIC bed base, whether nursing, care staff or ancillary staff, will work to a re-abling ethos. Every single interaction between staff and service users will be used as an opportunity to build confidence and relearn skills in order to regain independence.

People staying in a Leeds CIC bed base will have access to all the same health, care and support services that you would expect to receive in your own home. This could include input from specialist community teams, community nursing, a range of therapies, assistive equipment and, importantly, case management. We would like groups of communities in Leeds to have their own CIC bed base so that people are placed close to where they live. Neighbourhood Teams and care services will develop strong working relationships with staff working in the bed base for their area. Staff working in the home, medical staff and community health and care staff will work closely with each individual person and their family/friends as a multi-disciplinary team. This is to ensure that people receive a cohesive and comprehensive service to support them back into their own home in a timely way and also to ensure that the right care and support is continued once they are back at home. If returning home is not possible, the multi-disciplinary team will work in the same way to ensure a successful move into other accommodation or another care setting. Everyone who is admitted into the CIC bed service will be allocated a case manager from their Neighbourhood Team if they have not already been allocated one. Indeed, in the case of hospital referrals, a community case manager should be allocated. This crucial individual will be the 'golden thread' for each person and will navigate them through services and back into their own home. They will be the first point of contact for a person and their families/carers whenever they need information and explanation.

The CIC bed service will take account of the health and well-being of the 'whole person' and will approach each person as the unique individual that they are. The service will acknowledge that a person's successful return home to independence is as much determined by their confidence, mental health and support networks as it is by their need for physical rehabilitation and clinical care. The CIC bed service will collaborate with local third sector organisations such as Neighbourhood Networks or befriending services in order to tackle social isolation, as part of the planning for discharge from the service. As when older people are discharged from hospital, support should be in place when people return home to ensure that their home is warm, that they have provisions in the fridge and that, if requested, neighbours are aware etc.

Nobody will be denied access to the CIC bed service on the basis of a medical diagnosis or a condition. The decision as to whether a CIC bed base is a suitable location for their care will be judged on the circumstances, needs and risks associated with that individual balanced with the ability of the service to meet their needs at that point in time. Large numbers of people will have needs associated with their mental health, including dementia. All staff working in the CIC bed service will be trained and skilled in working with people who have these needs. The service can expect support to raise awareness and build capacity to support people with mental health issues from specialist mental health staff and community staff. The service can also expect timely advice and support to help meet the need of individuals. Only by exception, where individuals with mental health needs cannot reasonably have their needs met in the generic CIC bed service will alternative specialist services be considered.

The new specification is an opportunity to be clear on which types of need the CIC Bed Service should be expected to meet and which it should not. It is not sensible to specify this in great detail (given that each person being potentially referred has a unique range of needs) but the new specification does set down some principles. In recent years, CIC bed providers have reported on the increasing dependency and complexity of CIC bed service users and an increasing sense that they are expected to be 'all things to all people' . There are significant challenges to meeting the needs of people that require higher levels of clinical support in a care home environment and with staffing levels associated with this type of the care. It is often economically unviable to do this in the community. The new service specification emphasises that the CIC Bed Service has as its foundation a care home model of care, i.e. one where the social care needs of the person form the basis of the service, based on a re-abling/rehabilitative ethos and with nursing input where needed.

The service remains aimed primarily at older people who cannot return directly home after a stay in hospital or who could benefit from a stay in the CIC bed service in order to avoid a hospital admission and who require one or more of the 'three R's':-

Recovery - i.e. recuperation
Rehabilitation - Active therapy led interventions aimed at maximising a person's potential where early rehabilitation will benefit
Re-ablement - Optimising a person's independence within agreed short term and goal focused care plans

We should increasingly work to the principle that a decision to refer to long-term residential / nursing care directly from a hospital bed should only be made by exception and that assessment for ongoing care needs should take place in the community and only once an individual has had the opportunity to reach their full recovery potential. Extending this opportunity to more people would represent an expansion of the current intermediate tier and this impact is being modelled.

<u>A fresh approach to commissioning and delivering the CIC bed service</u>
Currently the CIC beds are commissioned through a variety of contracts and in many cases the therapy services are commissioned separately from the 'bed' services and from separate providers. There also exists a variety of 'sub-types' of CIC bed. This leads to nuanced eligibility criteria and a model which does not acknowledge that people's needs are dynamic and not static. It is difficult to explain the service offer to the public and to professionals alike. Furthermore, it is unclear as to who takes responsibility for the outcomes for people. Performance is notionally everyone's responsibility and yet nobody's, as nobody has been given responsibility for delivering an overall service.

For these reasons we need to commission the CIC bed service in a different way. The delivery of CIC beds requires a range of components if we are to successfully deliver the new service as outlined above. It requires appropriate care home estate, hotel services, personal care, nursing input, therapies, third sector input, wider community service input and specialist mental health input amongst other things. Rather than contract with different providers for these different components of a CIC bed service, Leeds commissioners want the service delivered through a single contract, to a single service specification, for a single coherent service.

The expectation is that there is one lead provider per bed base. This means that providers will need to collaborate in order to construct a single service offer. A further benefit of this commissioning/delivery approach should be greater staffing flexibility to manage fluctuations in need across the different bed bases.

Commissioners recognise that this is radical change to how CIC beds are currently commissioned and that we need, therefore, to provide the time and structure for providers to have these conversations and agree service proposals.

Another important piece of context is that the major part of funding for CIC beds sits within the Better Care Fund pooled commissioning budget between the Leeds Clinical Commissioning Groups and Leeds City Council. This is appropriate as CIC beds are hugely important to both Health and Social Care and a joint strategic commissioning approach is therefore essential. The new specification for the CIC bed service is therefore based on a joint Health and Social Care perspective. Furthermore it has been co-produced with input from all relevant stakeholders, providers, clinicians and service users. It can genuinely claim to be a Leeds consensus on how we want CIC beds to be delivered.

Further reasons we want a new model for CIC beds;

- Changes in the public demand for and expectations of the service
- Changes to the way we are providing community health and social care services in an integrated way and based on local communities
- The increased recognition that we need to meet the holistic needs of individuals, from tackling social isolation and regaining lost confidence through to active rehabilitation needs
- The increased recognition that we need to work with people to jointly identify goals and aspirations
- An increased focus on proactively case managing and navigating individuals through services
- An uneven geographical spread of bed bases across the city
- A lack of consistency across the different bases
- A desire to spread the many examples of good practice across all the bed bases to achieve consistently high quality
- Delays in discharging people from CIC beds which limits capacity for new admissions
- A recognition that, in recent years, a significant number of people have entered CIC beds from hospital who have *clinical needs* that cannot be appropriately met in a care home environment. This requires a level of service and care environment that it is potentially not economically viable to provide in the community
- The growing prevalence of dementia in the population and the need to ensure that the CIC beds are able to meet the needs of the of the CIC bed service users who are also living with dementia
- The need to meet growing demand whilst ensuring the best return on investment

The key principles on which the new model is based;

- The new model is founded on the principles of the 2014 Leeds Community Bed Strategy
- Your bed at home is best – case managers and care providers should do everything they can to get people back to their own home. A CIC bed should only be for people for whom this is not safe or possible

- You should receive the same support and therapy in a CIC bed as you would expect in your own home- it's simply a different location
- Each CIC bed base should be for a defined neighbourhood. This is to ensure that the bed base is close to people's homes and neighbourhood and that staff working in the bed base and staff working in other community services know each other and develop strong working relationships
- Flexible to meet a range of intermediate tier needs within a single building (no need to move people around)
- People receiving a case management service from the Neighbourhood Team to ensure that their stay in a CIC bed is appropriate and that they can return home or move to a new place of care in a timely way
- The service will promote self-management and take a strengths-based approach to care

SCHEDULE 2 – THE SERVICES

B. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.
All subheadings for local determination and agreement

Service Specification No.	1
Service	Intermediate Care Community Beds
Commissioner Lead	Sarah Lovell Associate Director
Provider Lead	
Period	
Date of Review	

1. Population Needs

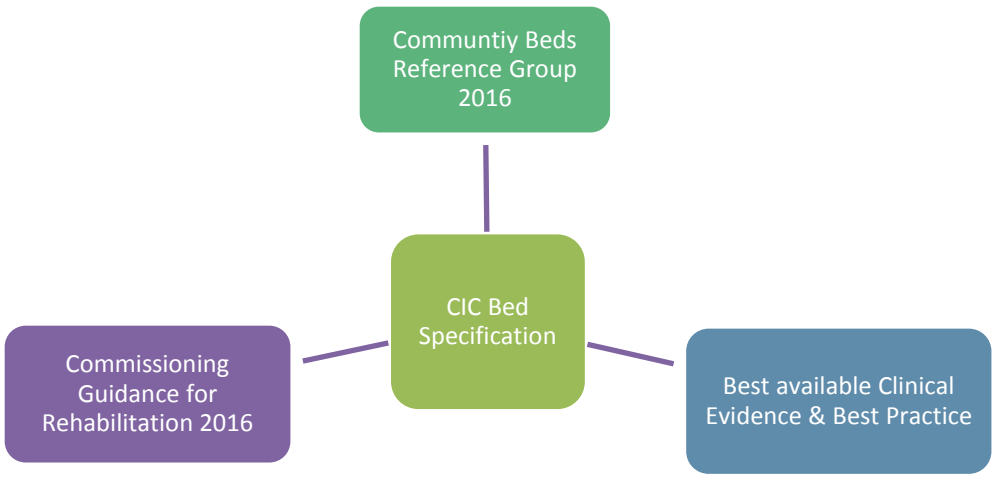
1.1 National/local context and evidence base

Leeds is facing unprecedented demand upon its health and social care services at a time when funding levels are reducing nationally. These challenges will intensify in the next few years as the population gets older and frailer. The numbers of residents with multiple and complex health and care needs continue to grow.

2. Outcomes

2.1 Local defined outcomes

The Service Specification is informed, influenced and inspired by 3 key areas:



Wherever possible we have used the words & phrases from the reference group and attributed direct quotes from other sources (ref 4.1).

The Leeds CIC Bed Reference Group 2016 identified the following outcomes using The Logic Model (Appendix 3)

Person Centred Care & Outcomes	Emotional Wellbeing	System Resilience

- Decisions in the best interests of the person, their families & carers
- Home & family circumstances taken in to account at discharge planning
- Sustainable care package that is responsive & personal
- Self-Medication provision
- Patient & Public know what the service is
- Therapy Outcome Measures

- Responsive & appropriate mental health services
- Mental health includes depression & anxiety as well as dementia
- Carers & Family support throughout the whole process
- Social Prescribing
- Satisfying work environment for staff

- Delivery of sustainable IC Services that meet the needs of the local population
- Shared responsibility between providers
- Reduced pressure in acute sector
- Better understanding of each providers role

The Outputs to achieve the Outcomes identified by the CIC Bed Reference group:

Active Rehabilitation

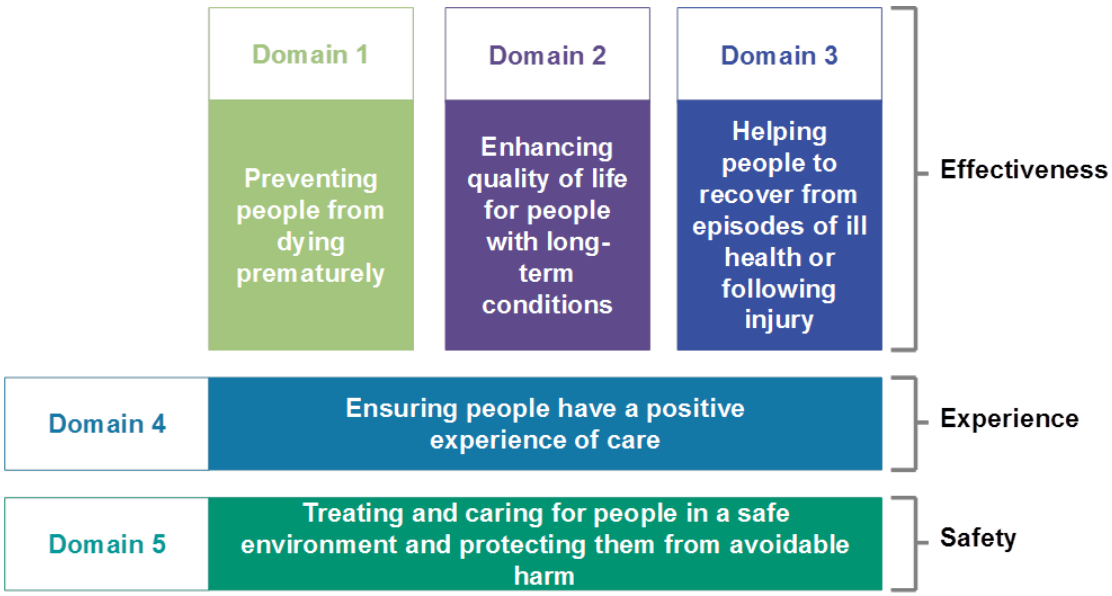
- Evidence Individual Goals Achieved
- Assessment in my own bed/chair
- Reach potential e.g. TOMS
- Person leaves with a personalised care plan to support self-management
- Dementia friendly

Collaboration

- Building of trust between professionals, people & families
- Risk management that is not risk averse
- People take informed risks
- New contract form: prime provider/alliance

Performance Measure	Performance Improvement
Avoidable admissions	Rate of admissions from community to increase from 23% to 31%
Length of stay	CIC: reduction from 30 to 27 T2A: reduction from 60 to 30
Readmission rates	50% reduction (equivalent of 10 community beds)
Delays in hospital	Reduce existing delays for patients awaiting intermediate care (25 patients at any one time) and residential care (25 at any one time) – using hospital 'medically fit for discharge' data.
Long Term Care	Reduce admissions by 5%
Patient experience	Composite score based on questionnaire
Provider experience	Composite score based on questionnaire

What the “Commissioning Guidance for Rehabilitation” (March 2016 NHS England) says:
The Government’s Mandate to NHS England for 2016/17 has an expectation that improvements will be demonstrated against the NHS Outcome Framework so as to provide evidence of progress and enable comparison of services locally.



Outcomes need to be meaningful to people who use services enabling them to maximise their potential, manage their own healthcare and promote independence (ref 5).

When considering what outcome data to request from providers, the following should be considered:

- What outcome data is already collected locally
- What outcome measurement tools are appropriate
- Will it enable benchmarking with other services
- Will it show how existing inequalities have been reduced in terms of access, experience and outcomes

There are several ways that rehabilitation intervention can deliver savings within the context of Health & Social Care. For example it can:

- Reduce the cost of nursing, residential & social care
- Reduce the risk of falls
- Reduce the risk of mental health illness
- Reduce length of stay

Good rehabilitation;

- Focuses on good outcomes that are set by the people we treat and driven by their goals
- Centres on people’s needs, not their diagnosis
- Aims high and includes vocational outcomes

- Is an active and enabling process – not passive care
- Relies on interdisciplinary team working
- Responds to changes in people's needs
- Integrates specialist and generalist services
- Requires leadership
- Gives Hope

The service will contribute to the following outcomes by which the service will be measured:

- Positive service user experience
- Enhanced levels of independence for people
- Greater choice for people through community options
- Increased numbers of people returning home with appropriate support and remaining independent in their home
- Reduction in long term care placements
- Reduction in unplanned acute admissions
- Reduction in delayed transfer of care from hospital
- Proportion of carers who say that they have been involved in discussions about the care of the person they care for
- Providers of the Leeds CIC bed service will be expected to work with commissioners to devise a monitoring regime that enables regular reporting of outcomes

3. Scope

3.1 Aims and Objectives of Service

Whilst there is no pre determined definition of intermediate care the following two lists help define the Intermediate Care Services in Leeds we have chosen to use Prof Philp's definition (adapted from Philp, Prof. I (2000). 'Intermediate care: the evidence base in practice'. London, RCP):

Intermediate care is;

- Person centred, with the development of an individual care plan
- About facilitating access to acute rehabilitation and long-term care services based on need
- About active rehabilitation
- Time limited, with clear entry and exit points and responsibility for managing transition
- Part of a whole system approach to the delivery of health and social care to older people and related groups

Intermediate care is not;

- Marginalising older people from mainstream services
- Solely the responsibility of one professional group
- Indeterminate care people under 18 years of age

- People identified with end of life needs (this does not exclude people who deteriorate during their placement with the provider and subsequently require end of life care)
- People where existing arrangements can be restarted without further assessment
- Transfer to assess may include people where only nursing / nursing EMI needs that can be safely managed in the CIC bed

Objectives of the Intermediate Care Community Care Beds (ref 2014 strategy);

1. Highest **quality care** - nursing, personal care, therapies
2. Consistent and accessible care/case management, founded on a self-management ethos
3. **Avoidance** of inappropriate acute **hospital admissions**
4. Facilitating timely and **smooth hospital discharge**
5. **Recognising the individual** – needs, wants, cultural needs and aspirations
6. Promoting **choice**
7. Identifying and supporting **carers**
8. Positive and seamless **experience** of the service
9. Highest standards of **dignity and privacy**
10. A **homely and dementia friendly environment** – providing quality meals, laundry, cleanliness, accessibility for visitors and families
11. **Maximise people's independence** and sustain it – through re-ablement, rehabilitation, an opportunity to recover, confidence-building and supportive self-management
12. **Empower** individuals to make personalised choices about their care and to self-manage their conditions
13. Everyone has a bed at home - Going **home is the goal** - not a day longer in a community bed than necessary
14. **Seamless transition to returning home** with the right support in place

The principles of good rehabilitative Care in intermediate Care Community Beds (ref 6)

1. Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs
2. Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team
3. Instil hope, support ambition and balance risk to maximise outcome and independence
4. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society
5. Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition
6. Support self-management through education and information to maintain health and wellbeing to achieve maximum potential
7. Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise,

technology, Cognitive Behavioural Therapy via primary care or community

8. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week
9. Have strong leadership and accountability at all levels – with effective communication
10. Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research

3.2 Service Description / Care Pathway

The service will provide a facility that focuses on short term strength based assessment (ref 13) rehabilitation, re-ablement and recovery care, delivered across multiple providers in collaboration, in a community setting that is person centred and dementia friendly.

Each person and their carers will be actively encouraged to work with staff to develop and implement a individualised person-centred care plan (ref 13).

As part of a whole system approach to the delivery of health and social care to older people and related groups the service will offer the following;

- **Recovery** – Support the person through the recovery phase whilst having access to diagnosis including geriatrician, treatment and prescribing interventions, personal and social care and time for recuperation where appropriate
- **Rehabilitation** - Active therapy led interventions aimed at optimising a person's potential and restoring autonomy where early intervention will be of benefit. Professionally assessed and goal/ outcome orientated and agreed with the individual
- **Re-ablement** - Optimising a person's independence within agreed short term and goal focused care plans. Care provided by generic and specialist health and social care workers working with the enablement ethos. Professionally led assessment, goals setting and monitoring

The focus of the community beds must equip people to live their lives, fulfil their maximum potential and recover from unexpected illness (the health conditions from which older people suffer which are most likely to lead to an admission to a residential care are not often prioritised by local NHS leaders e.g incontinence, dementia care, stroke recovery or falls prevention services (ref 15)). Rehabilitation achieves this by focusing on the impact that the health condition, developmental difficulty or disability has on the person's life, rather than focusing just on the diagnosis. It involves working in partnership with the person and those important to them so that they can maximise their potential and independence, and have choice and control over their own lives. It is a philosophy of care that helps to ensure people are included in their communities rather than being isolated from the mainstream and pushed through a system with ever dwindling hopes of leading a fulfilling life (Commissioning Guidance for rehabilitation 2016).

3.3 Population Covered

To support commissioning intentions for FY16/17, the Leeds Intelligence Hub undertook a detailed analysis of the population data held from 2011 to 2015. They used data on GP registrations and the ONS mid-year population estimates (Appendix 1).

3.4 Any acceptance and exclusion criteria and thresholds

The new CIC bed service criteria

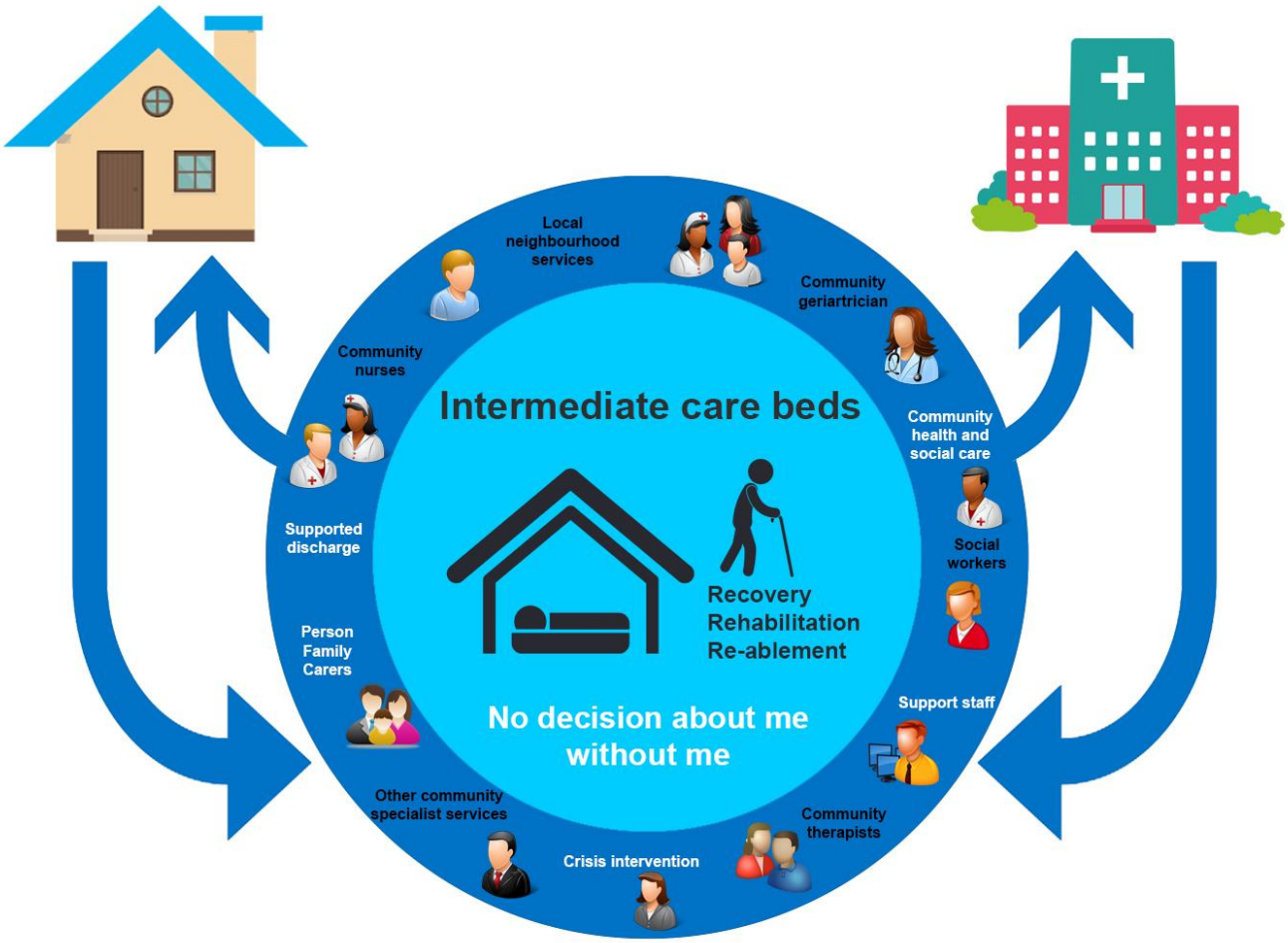
The new CIC bed service will approach each service user as an individual and jointly tailor care and support to that individual. That said, the service is designed to meet the needs of primarily older people who:-

- Cannot feasibly have their needs met within their own home ('home first' has to be at the forefront of everyone's mind)
- Require one or more of the 'three Rs'- an opportunity to recover (including regaining lost confidence), rehabilitation and re-ablement in order to return home
- Require a limited period of community assessment prior to agreement on their longer term care package (the 'Transfer to Assess' cohort)
- Have care and medical needs that can be safely and appropriately met in a community care home environment with support from primary care

Meeting the needs of more complex patients

NHS Commissioners acknowledge the fact that there is a cohort of patients whose care needs are such that they cannot be safely and appropriately met in a community care home environment but who are also deemed to be fit for hospital discharge. The level of care that this cohort of patients requires is sometimes termed 'sub-acute' or, more recently, 'post-acute'. The ageing demographic coupled with a narrowing definition of hospital care has meant that this cohort has increasingly been placed in CIC beds and there is evidence that CIC bed providers have struggled to meet their needs. Commissioners are working with providers to identify a solution to meet the needs of this cohort. This needs to be in place alongside, but distinct from, the new CIC bed service. A key part of defining this solution is understanding the relative economic viability of providing a highly specified nursing service in a care home as opposed to within a hospital infrastructure.

This model below depicts the relationships between the intermediate care beds and the neighbourhoods



3.5 Interdependence with other services / providers

The CIC Bed providers will be expected to interface, liaise and collaborate with a number of organisations. Below is a summary but not an exhaustive list.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The national and local policy drivers for intermediate care services are detailed in the Leeds Intermediate Tier Strategy but specifically this service will support the delivery of national agenda's:

- NHS Five Year Forward View (Oct 2014)
- Leeds Community Beds Reference Group for Service Specification development 2016
- Leeds Community Care Bed Leeds Community Beds Strategy 2014-2019
- Leeds Older People's Strategy
- Putting people first by delivering personalised care
- NHS England Commissioning guidance for rehabilitation, NHS England (March 2016)
- The King's Fund making our health care systems fit for an ageing population 2014
- Rehabilitation is everyone's business: Principles and expectations for good adult rehabilitation Version number: 1.0 First published: June 2015
- National dementia strategy (DOH 2009)
- Intermediate Care – Halfway Home Intermediate Care, 2009, *Updated Guidance for the NHS and Local Authorities*
- Putting People First (Transforming Adult Social Care)
- Living Well with Dementia- the national dementia strategy
- Strength's based social work programme re self-management programme
- Leeds Sustainability and Transformation Plan 2016
- Health and Social Care Act 2012
- Living Well with Dementia - the national dementia strategy

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

The provider will comply with the CQC Fundamental Standards 2015, the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014 and Care Quality Commission (Registration) Regulations 2009 in their entirety, whilst providing the service under this agreement.

The provider, as a Managing Authority under the Mental Capacity Act 2005, is responsible for ensuring that its staff is trained and practice in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and their respective Codes of Practice. The provider must have policies in place to inform practice. Specifically assessments of capacity, best interest decisions and instructing Independent Mental Capacity Advocates (IMCA), and requesting DoLS authorisations should be recorded when undertaken. The provider must ensure that no one is illegally deprived of their liberty. The provider must ensure that the person and their carer receive information and advice relating to substitute decision making provisions such as Advanced Decisions, Lasting Powers of Attorney and Court Appointed Deputies.

General requirements;

- The provider is responsible for ensuring that the number of beds and rooms stated in the contract are available including space for space for specialist bariatric equipment and that the service specification is complied with
- All staff work towards developing a competency in the delivery of rehabilitation using a philosophy of enablement and application of the social model of disability
- Delivery of holistic care and if not the sole provider, will proactively engage other providers to ensure all needs are met in accordance with the individual's needs and the requirements of the specification
- The provider is responsible, together with partner providers, for ensuring an integrated approach to managing case records. The provider must ensure up to date, accurate and concise records are maintained and available for either the individual or the partner services. On admission all people will be provided with personal information file and agreed documentation used (single assessment process). This will form the individual integrated assessment and care planning documentation. Only sensitive information will be recorded elsewhere
- All partners will work to together to establish a system for sharing electronic records. Information sharing between agencies is also essential to ensure a seamless service, so arrangements need to be made for appropriate IT systems and facilities. The use of mobile, shared electronic records will be particularly important where staff teams work in community and home-based settings (ref 10)
- The provider is responsible for ensuring that its service meets the requirements for safeguarding adults detailed in the service specification as part of contractual arrangements

People will be active partners in the planning and decision (no decision about me without me) making process for their rehabilitation throughout their stay. Providers will develop a CIC bed facility that prides itself on embracing a philosophy that puts active rehabilitation and strength based approaches at its heart. Where all parties strive to support and enable the person to have choice and control over their lives and be as independent as possible. Staff will be supported to access and develop the necessary skills to enable this to happen through joint leadership, clinical supervision, appraisal and access to training.

Carers / Families often know the people that they care for better than anyone else and this knowledge can be extremely useful in planning a person's care. Engagement and co-operation with carers is therefore an essential part of good care. Furthermore, co-operation is often needed from carers to effectively implement any patient care plan, and so involving the carer when devising a care plan, and listening to his or her views, is likely to result in better concordance.

However, carers also tend to neglect their own health for a variety of reasons and so whenever a carer is identified; it is always worth enquiring about their well-being. This may help to identify carer health problems, which if ignored may impact upon the health and wellbeing of both the carer and the person they care for.

The provider is responsible for:

- Identifying carers and recognising that they may need help both in their caring role and in maintaining their own health and well-being
- Involving the carer in the development of patient care plans and discharge plans and ensure that the impact of caring is fully considered
- Providing carers with information about support that is available for them (e.g. Carers Centre)

Therapy Input

Older people should receive adequate rehabilitation and re-ablement when needed, to prevent permanent disability, greater reliance on care and support, avoidable admissions to hospital, delayed discharge from hospital, and to provide adequate periods of assessment and recovery before any decision is made to move into long-term care. Rehabilitation and re-ablement are two services on a continuum of intermediate care. Rehabilitation is primarily a health model that includes physical therapy and occupational therapy to prevent admission to acute care or facilitate a stepped pathway out of hospital. Re-ablement is primarily a social care model that focuses on promoting and optimising independent functioning rather than resolving health issues (ref 14).

Therapy will primarily be delivered by Physiotherapists and Occupational Therapists in collaboration with the person, their families and all staff to the principles of “Rehabilitation is Everyone’s Business”. Therapists will provide assessment, advice and support for individuals and their families as well as guiding and contributing the wider Care Team and Multi-Disciplinary Team.

Specialist therapy input will be accessible on an individual needs basis e.g. Speech & Language Therapy. Psychological therapy will be included in the overall mental health input. Therapists will work with the person and their families both in the Care setting and the Community setting to achieve the person’s ambitions and goals. Where possible and appropriate, therapists will enable access to community rehabilitation settings in both statutory and non-statutory settings prior to discharge and support non-therapy staff to implement therapy based care programmes as agents of therapy.

Formal therapy (registered) and initial assessments will be available 7 days a week in conjunction with the whole care team working to a rehabilitation model.

Medical cover

All people admitted to the CIC beds will receive a primary care service commissioned by local NHS Commissioners.

They will be registered with the primary care practice providing cover to the beds the exception is when the person’s own GP continues to provide cover. Access to specialist medical assessment/support via geriatrician will be by direct referral or through MDT meetings. Access to other specialist support e.g. dietitians, tissue viability or mental health support will be via direct access to the appropriate services.

Pharmacy

It is important that the facility has a robust and responsive pharmacy support 24 hours and 7 days of the week. There will be a robust medicines management policy in place working with the CCG's Medicines Management Team.

Discharge from the community care beds

It is expected that discharge planning will have been commenced when a person is admitted into a CIC bed in partnership with any relatives and carers. The NHS and social care partners should work together to ensure the person leaves the community bed once their treatment/rehabilitation is at a point that the person is safe to discharge home 7 days a week with good post-discharge support once back home to reduce the likelihood of readmission (ref 6). Should there be a requirement for a continuum of re-ablement, services are notified and plans and goals shared to maintain the progress made. Once a discharge date has been agreed the neighbourhood team will be notified of the anticipated date and support required.

Staff Training

Effective use of the community beds to manage a range of complexities and demands requires a range of specific training and competencies for all the team. Some members will have specific expertise e.g. nursing, therapy or dementia/mental health. On going access to specialist support to develop the skills and competences and ongoing training and development to meet expectations of the service. All members of the team should have the competencies to deliver the outcomes with focus on rehabilitation in a timely way. All staff should progress to a basic level of knowledge and skills to care for people with dementia and risk management. Therapists will support staff to develop competencies in delivering therapy based care plans.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable CQUIN goals (See Schedule 4E)

3/2/16

Monitoring process

The ultimate measure of the success of the service rests in its ability to successfully enable people where applicable to return to and remain in their own home and to prevent unnecessary and avoidable admissions to hospital or into long-term care.

All aspects of the service will work closely with the person, their carers, relatives and colleagues from the acute and primary care to facilitate a seamless transfer of care from hospital or the community into the CIC beds, through to discharge.

- Reduction in length of stay (LoS) of all individuals accessing the service
- Number of individuals discharged from the service

- Bed Occupancy Levels
- Number of days closed to admissions.
- Number of incidents reported to infection control
- Improvement in Therapy Outcomes Measures (TOMs) scores and EQ5D health status scores from admission to discharge
- Reduction in the number of older people transferring directly to long term care
- % people discharged to hospital from the unit (admissions and re-admissions)
- % of these originally admitted from the community
- % of these originally admitted from hospital
- Number of acute readmissions to hospital within 72 hours of admission to the service (for people that had originally been admitted from hospital)
- Number of days delayed discharge from service due to inability to discharge a person
- Customer satisfaction during stay in unit prior to discharge
- % receiving Tier 1 Falls assessment within 24 hours
- % with 3+ score on FRAT receiving Tier 2 assessment within 24 hours
- Circumstances/services received of people prior to unit and 3 months and 6 months post discharge from the service
- Number of people in long term care/ receiving an intensive level of care 3 months and 6 months post discharge from the service
- Number short stay hospital attendances 3 months and 6 months post discharge from the service
- Increased proportion of users from the community in relation to those discharged from hospital
- Referral source of those admitted to the service
- % of carers who say they have the right information and advice to help them in their caring role
- % of carers feel who say that they are respected as equal partners throughout the care process and that their knowledge has been used appropriately

6. Location of Provider Premises

The Provider's Premises will be distributed equitably across the city into localities.

7. Individual Person Placement

References

1. Discharging Older Patients
2. Care Quality Commission, The independent regulator of health and social care in England
3. Leeds older people's strategy
4. Putting patients first by delivering personalised care
5. Strengths based social work
6. NHS England Commissioning guidance for rehabilitation, NHS England (March 2016)
7. The kings Fund making our health care systems fir for an aging population 2014
8. Strategic Clinical Networks June 2015
9. Rehabilitation is everyone's business: Principles and expectations for good adult rehabilitation Version number: 1.0 First published: June 2015
10. National dementia strategy(DOH 2009)
11. Intermediate Care – Halfway Home Intermediate Care, 2009, *Updated Guidance for the NHS and Local Authorities*
12. Health and high quality care for all, now and for future generations Commissioning for Carers
13. Strength based assessment and care planning
14. Making our health and care systems fit for an ageing population Authors David Oliver Catherine Foot Richard Humphries… Kings Fund 2014 (chapter 6, page 33)
15. A report of investigations into unsafe discharge from hospital, parliamentary and Health service ombudsman. May 2016
16. IPC institute of public care April 2106

Appendices

1. Population Covered
2. Leeds CIC bed reference group members 2016
3. Leeds CIC bed reference group Logic model 2016

Appendix 1 – Population Covered

Whilst there are some discrepancies between the two data sources this is predominately around working aged adults. Based on these sources, Table 1 below presents a set of growth rate ranges for 2016/17.

Table 1. Proposed growth rates for Leeds's registered population based on the ONS MYEs and GP Registrations data sources.

Age Band	Annual % Growth Rate
00 - 19 years	1.3 to 1.5%
20 - 39 years	0.3 to 1.2%
40 -59 years	0.2 to 1.1%
60 -74 years	0.9 to 1.1%
75 years plus	0.9 to 1.2%

Figure 1 (a) Absolute and **(b)** relative change in the registered population of Leeds between July 2014 and July 2015 by five year age-sex band based on the GP Registers dataset.

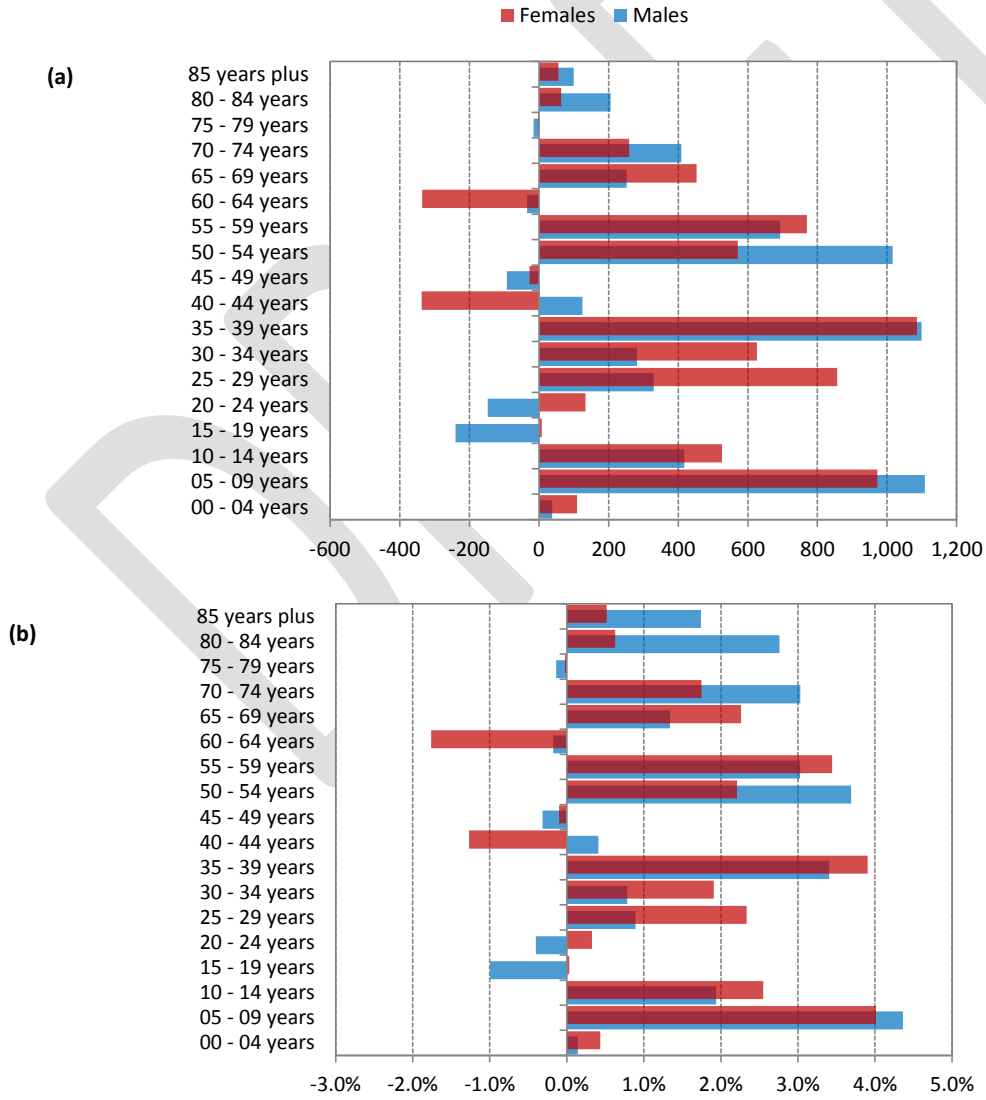
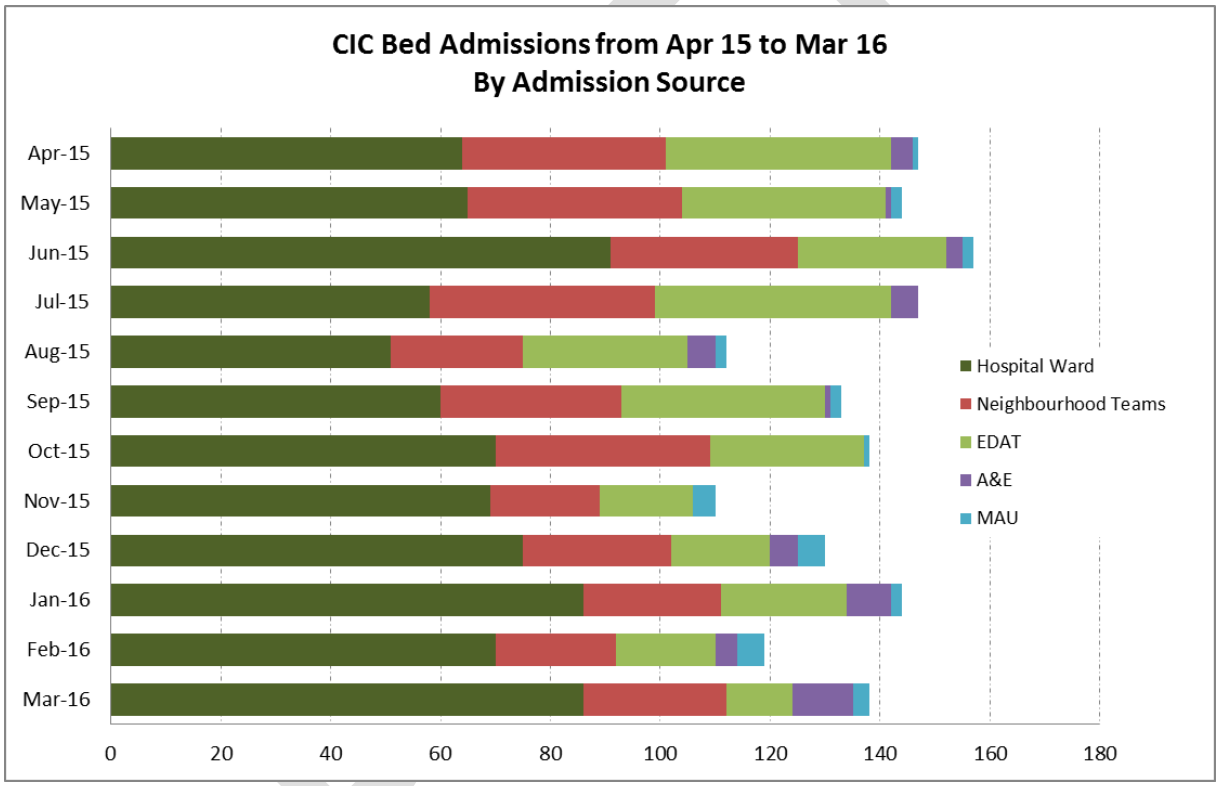


Table 2. Three-year average growth rates by age band for the three Leeds CCGs based on GP Registration data.

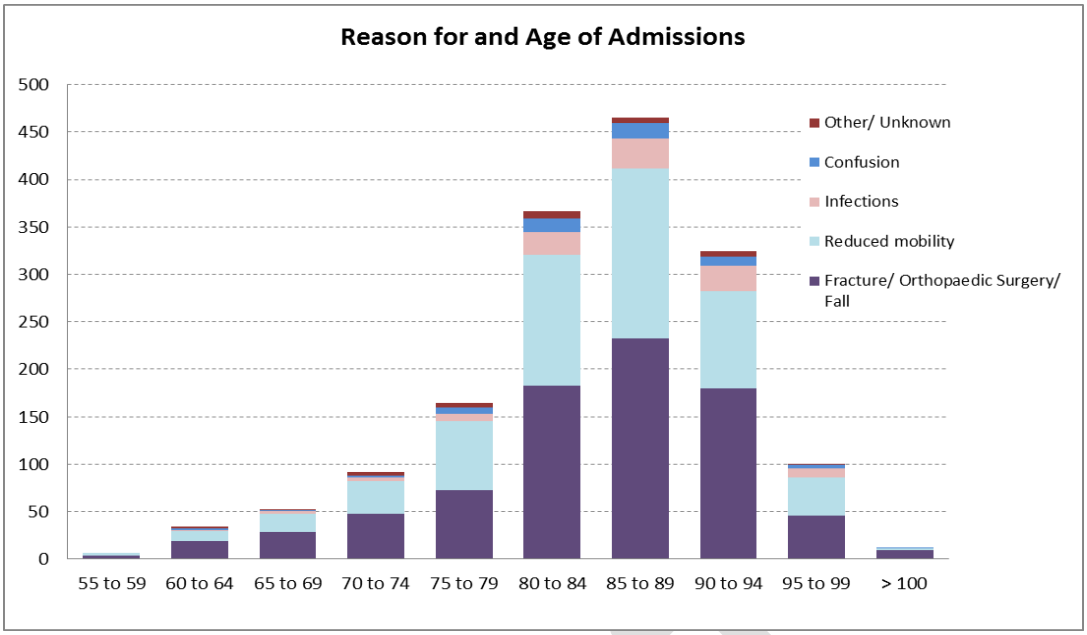
	Leeds North CCG	Leeds South & East CCG	Leeds West CCG
0 to 19 years	0.8%	1.4%	1.0%
20 to 39 years	0.9%	1.3%	0.4%
40 to 59 years	1.2%	1.4%	1.0%
60 to 74 years	1.3%	0.6%	1.2%
75 years plus	1.2%	1.3%	0.8%
All Ages	1.0%	1.2%	0.8%

CIC Bed 2015_16 Performance Summary

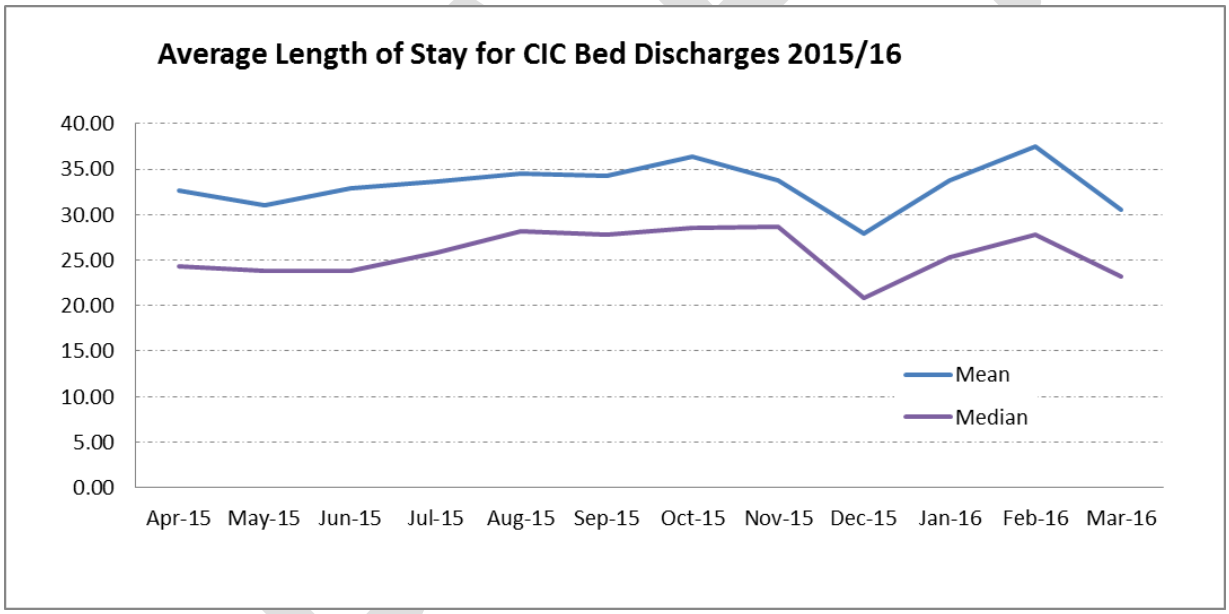
Throughout 2015/16 there have been on average 135 admissions per month to CIC Beds across the city. 52% of those people were admitted directly from hospital wards with 23% being admitted directly from the community. The Early Discharge Assessment Team, working within Leeds Teaching Hospital Trust was responsible for a further 20% of admissions to CIC Beds.



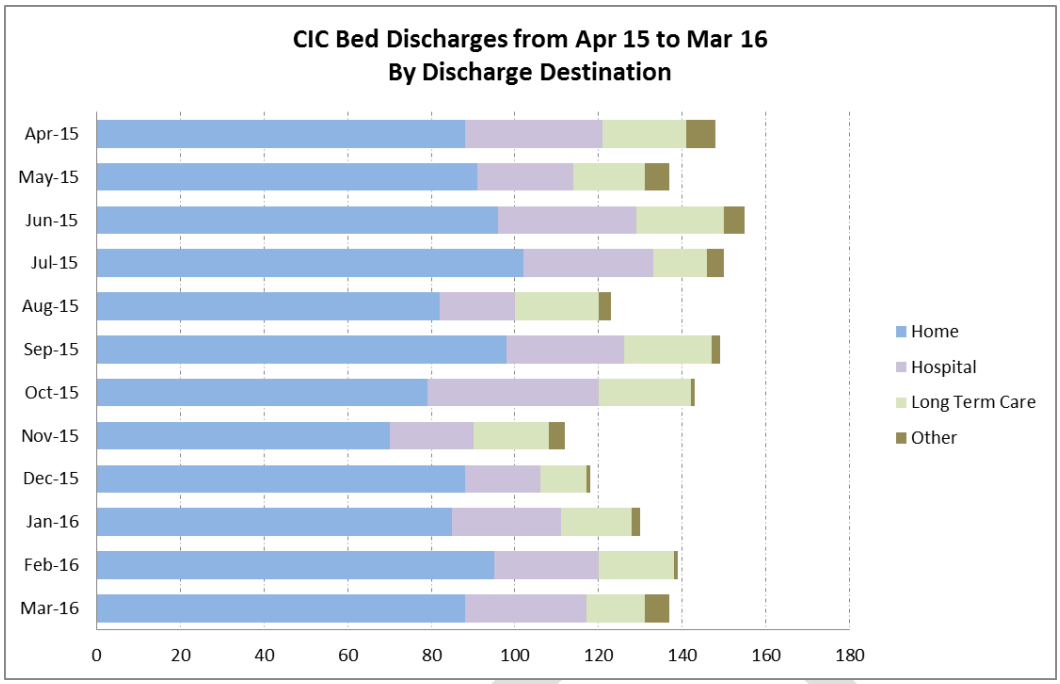
People aged between 80 and 94 make up the largest cohort of CIC bed users and the overwhelming majority of people are being admitted with falls, fractures or reduced mobility.



On average people stay around 33 days, but this figure is distorted by long stayers. The most common length of stay is 26 days.



Throughout 2015/16 there have been an average of 137 discharges per month with the majority of people (67%) being discharged home. 20% are admitted into hospital and 13% are sent into long term care.



Appendix 2 Leeds CIC bed reference group members 2016

Name	Organisation	Job Title
Bernadette Bell	LSE	Commissioning Manager

Karen Benton	LCH	Clinical Service Manager
Brian Ratner	LCC	Service Delivery Manager
Chris Brindle	LW CCG	Engagement Lead NHS Leeds West Clinical Commissioning Group (CCG)
Julie Budd	LYPFT	Clinical Team Manager
Chris Argyle	Physio Network	Physio
Chris Peters	LCC	PSM
Lesley Freeman	LSE CCG	GP/Clinical Lead
Joanna Gare	LSE CCG	Project Lead
Alison Gordon	LYPFT	Clinical Operations Manager
Jenny Minton	LCC	Registered Manager
Vivien Lewis	LTHT	Head of Nursing for Discharge
Sarah Lovell	LSE CCG	Associate Director of Commissioning , Strategy and Performance
Caroline McNamara	LCH	Clinical Lead, Adult Services
Gary Poxton	LYPFT	Programme Manager - Older Peoples Services Mental Health Redesign
Megan Rowlands	LCH	General Manager, Adult Services
Stephen Elsmere	West CCG	Patient Leader
Tony Sykes	West CCG	Patient Leader
Nicola Turner	LTHT	Consultant Geriatrician
Emma Wheadon	LCH	Clinical/Professional lead
James Woodhead	LSE CCG / LCC	Commissioning Manager
Frances Leighton	Orchard Care Homes	Greenacres Manager
Jan Hampshire	AMORECARE	Atkinson Court

Appendix 3 - Leeds CIC bed reference group Logic model

VISION: TO DELIVER PERSON CENTRED ACTIVE REHABILITATION, WHICH IS TIME LIMITED AND PART OF A WHOLE SYSTEM APPROACH TO THE DELIVERY OF HEALTH AND SOCIAL CARE TO OLDER PEOPLE LIVING IN LEEDS

Inputs	Activities & Processes	Outputs
Person info/ communication Families involved Involving as many what the person wants to achieve Move beyond professional boundaries Third sector services Skilled staff appropriately trained: mental health, physical awareness, dementia, competencies to meet need Environment and facilities tailored to meet needs e.g. communal areas, chairs, fall- friendly flooring and lighting, gym, home from home? *Recurrent funding*	Agree goal , activities, EDD on admission Home assessment visits at home? Personalised patient centred care planning Dedicated ?social worker/assistant E-rostering/flexible Care plan focus on skill mix as opposed to qualifications 7x7 service MDT *(to avoid unnecessary delays that might adversely affect performance outputs and outcomes)* • *Physiotherapy* • *Occupational therapy* • *Podiatry/Dietetics?* • *Support to regain social independent social independence* • *Self-management* • *Nursing* • *Medicines optimisation* • *GP and physician* • *Activities coordinator* Access to diagnostics Use of IT *New specification*	Active rehabilitation Evidence that goals achieved Assessment in my own bed/chair Risk managed in the least risk adverse way Building trust between professionals and patients/families Reach potential i.e. TOMs *Patient leaves with a personalised care plan to support self-management* Trust between professional groups People can take informed risks Environments dementia design Appropriate enabling equipment Performance Improvement in avoidable admissions, length of stay, readmission rates, delays in hospital, long term care, patient experience, provider experience

OUTCOME

Decisions made in the interest of patients, carers, families
Person centred care:
- Sustainable care package, responsive personalisation
- Personal outcomes
- Self-medication provision
- Prevention strategy
- Patient satisfaction

Patients and public to understand what the service is
Home environment and circumstances of family and friends taken into account e.g. discharging patients on their request.

Satisfying working environment

Reduce pressures on acute sector
Better understanding of each provider's role in:
Delivering IC services
Improving system resilience
Delivery of sustainable IC services that meet the needs of local populations.

Shared accountability between providers of activities and processes

ASSUMPTIONS: Sufficient staffing of the right type throughout the system. Motivated staff. Everyone understanding person centred care and personalisation. Carers/families involved at all times. Flexible environment - falls and dementia. Medical response to avoid inappropriate 999 calls. Advanced care planning for potential eventualities. IT joined up to enable Information sharing e.g. EPR Results server. Discharge is facilitated and ICT have sufficient resources to meet demand. Enough money to commission this model and enough providers to deliver the model. Enough capacity in GPs, neighbourhood teams, reablement services to support patients and prevention strategies. Enough acute hospital, specialist rehab and long term care beds to avoid inappropriate referrals to this service.