# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.*

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| **Service Specification No.** | Short Term Care Home Nursing Care  |
| **Service** | East Berkshire - Intermediate Care |
| **Commissioner Lead** | Rachel Wakefield / Jo Greengrass |
| **Provider Lead** | TBC |
| **Period** | 1st February 2020 – 31st March 2023(TBC**)** |
| **Date of Review** | March 2023 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**

 ‘Imagine leaving your home and never returning to it again’‘Imagine someone tells you that you are moving house tomorrow and you have no control over where you are moving to and how much it will cost’.This is what is done to thousands of older people every year after they are admitted to hospital, often with a mild to moderate illness on top of any pre-existing conditions. We make judgements about how the person will manage when they return home based on perceptions about the person after the effects of a stay in hospital, often prolonged. We assess them in an environment that is alien and confusing East Berkshire CCG is committed to commissioning High Quality Care for the people of East Berkshire which promotes the thinking of ‘Home First’ (wherever possible) through admission avoidance (step up community beds) or at the point of discharge from an acute bed. Through integrated and collaborative working that engages the person as well as the health, social care professionals and others involved in their care, individuals can be given the opportunity to recuperate from illness and other conditions (receiving care and nursing intervention as required) or supported through the delivery of individually tailored reablement and maintenance programmes (e.g. for people who are unable to weight bear for extended periods) to achieve a level of optimasation and independence that is acceptable to them. A comprehensive assessment in respect of any potential requirement for health, social care or other longer term services can then be carried out in the right place, at the right time and by the right person.East Berkshire CCG intends to commission a CQC registered (with Nursing) care home provider, that will work with the CCG, local acute providers, social care partners, and the wider integrated care system partners (including the third sector) to provide Care with Nursing for individuals (including those with dementia or delirium ) who require 24 hour overview by a Registered Nurse and a period of time in a community bed for either the purpose of admission avoidance or under the framework of discharge to assess. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**

| **Domain 1** | **Preventing people from dying prematurely** | **x** |
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| **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **x** |
| **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **x** |
| **Domain 4** | **Ensuring people have a positive experience of care** | **x** |
| **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **x** |

**2.2 Local defined outcomes**Through integrated working the local health, social and private care system will:* Promote the principle that individuals should be supported to return home to recover from their admission to hospital with the practice of making decisions about long term care in a hospital setting ceasing.
* Help ensure that people are in hospital for the shortest possible time while medical and nursing needs that can only be delivered in an acute hospital setting happen there.
* Support the ‘Home First’ approach where all lower level care, recovery, rehabilitation and re-ablement should happen wherever possible in the persons’ usual place of residence, but when this isn’t possible in a safe and appropriate community setting.
* Continue in this mind set when the multi-disciplinary team are working with the individual in planning discharge from a ‘step down’ or ‘step up’ community bed – ‘Home First’

In turn, individuals will receive the care and support that is required and will be in a better position to take part in assessments to understand and inform their longer term needs, while as a system the achievement of local and national indicators for urgent and emergency care will also be supported.These are to:* Reduce overall length of stay in an acute hospital setting
* Sustain and continue to improve patient flow inside the acute hospital to deliver a reduced bed occupancy of 92%
* Reduce delays in transfer of care (DTOC’s) to below 3.5%
* Reduce the number of NHS continuing care assessments undertaken in an acute setting to below 15%
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| **3. Scope** |
| **3.1 Aims and objectives of service**To provide a positive and responsive 'can do' Care with Nursing service which operates as part of a continuum of services that seeks out and promotes the needs of the individual to support the:* Maximisation of wellbeing
* Maximisation of individual choice and control
* Maximisation of independence and functioning
* Minimisation of intervention

which supports the Acute hospital and wider system to: * Operate effectively and efficiently, in the best interests of the individual and the wider system; representing value for money for residents of East Berkshire

by:* Receiving individuals into the home under ‘Trusted Assessor' arrangements.
* Providing the individual who is identified as requiring further assessment and /or multi agency intervention (both in the community and in hospital) with timely access to a care home bed - i.e. within 4 hours of the bed becoming available. (EB CCG to be notified should the home not be able to meet this target e.g. due to the room needing additional refurbishment such as new carpets
* Working as part of the Multi-Disciplinary Team / multi agency providing comprehensive assessment, intervention, support and nursing care as required.
* Promoting independence and improving outcomes for individuals recovering from illness, injury or trauma by providing individualised assessment (encompassing the person’s physical, medical, social and psychological needs), treatment and periods of reablement or recuperation to enable them re-gain sufficient physical functioning and confidence to return safely to their own home wherever possible, respecting the individual's wishes and preferences
* Providing holistic care that facilitates the individual to identify their personal and potential, achievable goals which support the person in reaching their optimum level of independence and with planning their future lives
* Ensuring that all staff are trained in and proactively promote the individual's independence, supporting reablement approaches and delivering agreed plans between visits from the community teams (this will include working with community nursing providers and clinical governance to provide intermittent IV therapy e.g. antibiotics and / or sub cut fluids)
* Involving the individual, their families and carers as appropriate at all stages of the individuals care planning so they retain control of their own lifestyle as far as possible (whilst considering the levels of capacity a person has to make informed decisions as per the Mental Capacity Act)
* Helping to reduce possible dependency on carers/family or care packages; provide support and education to carers and families in relation to care delivery
* Providing appropriate help, advice and support for carers and ensuring that the individual's carers and family are supported with any carer issues identified either through resolution or escalation to appropriate parties (with the appropriate permissions) to support resolution
* Identifying, assessing, making recommendations and taking actions with regards to areas of risk
* Preventing unnecessary hospital admission admission to acute settings from appropriate hospital departments (e.g. A&E, Ambulatory Care) and from the community
* Preventing premature admission into long-term care provision
* Facilitating hospital discharge over the 7 Day period; providing a flexible approach to accepting individuals - as long as the home is able to meet their presenting needs
* Maximising opportunities in relation to same day attendance within the acute hospital where further consultant opinion or investigations are required e.g. accessing a facility or ambulatory care unit (the provider is required to actively manage same day attendance and accept the individual returning back into the unit on the same day of attendance
* Providing effective, high quality, clinical management for individuals, contributing to the multi­ agency assessment, supporting and assisting the person to meet identified re-ablement promotion of independence goals within a maximum period of six weeks ( this period can be extended e.g. for non-weight bearing individuals, but is subject to weekly multi-disciplinary review and action, recorded and agreed at weekly MDT meetings).
* Working with colleagues from the NHS and Social Care in producing agreed operational guidance in relation to individuals requiring step up or step down care and intervention.
* Supporting onward transfer of care where required, improving standards of care and the individual's experience.

It is important to understand that individuals and their families may find it difficult to make decisions or practical arrangements for many other reasons, some of which include: * A perceived or actual lack of knowledge about available options and how services and systems work (often feeling that they have insufficient information and support)
* Concerns about the quality or the cost of care (there is often uncertainty or conflict about who will cover these costs)
* Worries around moving into interim accommodation with another move at a later stage
* Available choices are not compatible with the individual’s preferences
* Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge
* Worry around how much family and carers can and will do to support them.

The consequences and impact of not achieving the aims and objectives can be far reaching:* Exposure to the unnecessary risk of hospital acquired infection
* Deconditioning, physical decline and loss of mobility / muscle use
* Potential for increased risk of falling and sustaining injury
* Potential to develop or for worsening of existing confusional state
* Increased individual dependence; the hospital environment is not designed to meet the needs of people who are medically stable and ready for discharge. Consequently, this dependence is reflected in any needs assessment potentially causing further delay to discharge while agreement of next steps is reached
* Frustration and distress for both the individual and their relatives due to uncertainty or where there may be a wait for the availability of preferred choice
* Severely unwell individuals unable to access services due to beds being occupied by individuals who are medically fit for discharge
* Unnecessary cost and inappropriate use of valuable resource (monetary and workforce) within the local health and social care economy

A quality schedule to monitor outputs against the aims and objectives will be implemented within the contract.**3.2 Service description/care pathway**The service will focus on those who are at high risk of:* Admission to long term residential care
* Prolonged hospital stay
* Inappropriate admission to acute inpatient care setting

As part of the wider integrated system, provision of short term beds will be responsive to individual presenting need which may mean that a person admitted to the care home may be transferred to a community hospital or to a short term residential reablement service.The provider will ensure that both the individual and their carer’s are aware that this service is a short­ term provision. Therefore any onward service (e.g. within the Provider's own Home) is not guaranteed as any future care required will be agreed in conjunction with the individual and their carer, based on the individuals presenting need at the end of their stay in the home. The provider is therefore expected to advise the CCG immediately that the period of time the individual is with the provider is likely to exceed the expected date of discharge due to local authority delays (local authorities have an duty of care in supporting identified individuals placed in short term beds), personal circumstances or for any other reason. **Sources of referral (this list is not exhaustive)*** Frimley Health Foundation Trust
* Berkshire Health Foundation Trust may refer individuals who do not require the input of a community hospital bed
* Social Care teams
* GP’s and other providers for the purposes of admission avoidance

**Referral Process from Wexham Park Hospital**Referrals made from **Wexham Park Hospital** will be via a Discharge Passport. It is anticipated that this will also become the mechanism of referral from both the local community trust and Social Care Partners in due course.The referring responsibilities will include:* Obtaining informed consent from the individual to step down to a community bed
* Informing the individuals Next of Kin of the planned transfer
* **Comprehensive and accurate completion** of the Discharge Passport (including name and contact details of the referrer)
* Provision of a transfer letter’ to the individual and, where appropriate, their relative

**Acceptance by and Discharge from a step down / step up bed**The care home should make a decision to accept or decline the transfer of an individual within 2 hours of receiving the required information. The decision can be communicated via email or telephone; if the individual is not accepted, then the reason for this must be communicated to the referrer.Once an individual is accepted, the referring organisation is responsible for making arrangements to facilitate discharge on, or before the estimated date of discharge (EDD) documented on the discharge passport (if this is the documentation used to refer). These responsibilities include:* Ensuring that transport is arranged where this is required
* Ensuring that a copy of the discharge summary (and any other relevant documentation such as a DNACPR document)
* Two weeks supply of prescribed medication are ready to accompany the individual on their discharge
* Liaison with both the individual and where appropriate, their relatives with regards to discharge arrangements

On the day of transfer, individuals should be routinely arriving at the care home before lunch. Transfers are expected to take place seven days per week (incl. bank holidays). In extreme circumstances (high system pressures / major incidents) the home should be able to accept individuals up until 8pm and be able to ‘flex’ resources to facilitate multiply admissions on any given day. This must be discussed with the home manager and the EBCCGs Quality Team informed of all admissions between 8pm and 8am the next working day.​A list of all referrals made, and the outcome (accepted or declined by the provider) will be collated by referring organisations.**Trusted Assessment**The Care Home will be required to accept referrals through ‘trusted assessment’. Referrals will be made by an NHS (or other agreed professional) who will have completed a risk assessment (for example the discharge passport) for the safe transfer of care. Following any necessary verbal discussion, the individual will be transferred to the home without any further assessment from the home staff.Whilst the Discharge Passport will be the expected referral documentation from Wexham Park Hospital, completed frailty paperwork remains acceptable from other organisations where the discharge passport is not yet agreed for use – there may be other referral documentation agreed for use. The home may require further information prior to making an acceptance decision and should ask the referrer directly for this**After Admission** The home will be responsible for assessing care needs during the first 24 hours of admission and working collaboratively by including nursing care needs into the care plan. A GP assessment should also be undertaken within 48 hours of admission (see GP support section).Care home staff members are expected to work together with visiting therapists, social care staff and other professionals who will complement the assessment and care plans. The Provider will be required to complete referrals to all relevant services e.g. Tissue Viability, ensuring that the highest possible quality care is provided to the individual at all times.**Multi-Disciplinary (Integrated) Team**Core members from the list of stakeholders will be expected to attend MDT Meetings on a weekly basis. It is essential to have all members present in order that meaningful discussions can take place for each individual and an appropriate care plan developed. Core MDT members and additional members will be expected to carry out their relevant actions prior to the agreed review at the next MDT meeting. This will prevent delay and ensure the best outcome for their individuals.The Core membership requirement for the weekly MDT meetings are:  * Care Home Manager or a Deputy
* Social Worker RBWM
* Social Worker Slough Borough Council
* GP (depending on GP surgery time and commitments)

In addition, therapy representation from BHFT will be required when there are individuals from receiving therapy on a BHFT caseload:* Physiotherapist BHFT
* Occupational Therapist BHFT

Additional input may be requested from other professionals as and when individuals with specific needs are occupants of a step down bed:* EBCCG CHC team nurse assessor
* Community Psychiatric Nurse
* EBCCG GP Liaison
* Pharmacist
* GP Practice Staff (e.g. Practice Nurse)

(These lists are not exhaustive and may be subject to change during the contract period).The home will take responsibility for minute taking and documenting the MDT outcomes in the individual's medical and nursing records and for circulating the weekly MDT list including recorded actions and outcomes.**Community Service Input**Community service intervention (e.g. therapy) will be provided on a case by case basis for individuals referred for assessment and subsequent prescribed treatment or intervention. Where individuals are being discharged from an acute hospital setting, these referrals should be made prior to transfer as part of the planning and risk assessment process.Care home staff will be required to support an individual’s care plan where applicable.**General Practitioner Support**This is provided to the home by (TBC)On admission to the care home, individuals will be registered with the attached GP on a temporary residency basis for the duration of their stay (usually up to six weeks). The GP support to the home will include:- * Minimum of once weekly GP rounds to be held within the home; all individuals occupying a bed under this contract will be seen by the GP; the arrangement can be reviewed and the GP round increased to up to three times weekly by agreement.
* All individuals occupying a step down / up bed will be seen within 48hrs of admission, or on the following Monday should admission take place on Friday afternoon.
* In addition, a GP will visit and review any individuals on an ‘as required’ basis – this could result in the GPs visiting the home on a daily basis.
* Arranging for investigations to be undertaken as required e.g. blood tests, x-ray; specimens (e.g. blood, urine samples) can be sent to the Acute Hospital directly from the home once these have been requested and obtained.
* Arranging transport to and from hospital for individuals attending appointments as needed (it is anticipated that the acute hospital will arrange routine post hospital discharge follow up, along with the required transport)
* Appropriate management of individuals on Warfarin; checking INRs as required and ensure timely response / action according to results.
* Appropriate management of long term conditions
* Provision of appropriate care plans (e.g. anticipatory care) in conjunction with the wider MDT

At the end of an individual’s stay, the GP surgery will ensure the provision of:* Two weeks of medication (TTO’s) provided as required; this will include Dossett boxes or an alternative as required.
* A Discharge Summary to the receiving GP.

**Discharge Planning and leaving the short term bed**Discharge from a short term bed will, in all cases, be planned by the multi-disciplinary team in conjunction with an individual’s designated key worker to ensure smooth onward transfer to long term care. Transfer of care information must be completed and complemented by current care plans and, with the appropriate permissions, the information shared with the individual’s new care providers.A discharge summary will be required for all individuals leaving a short term bed, whether going home, to another rehab facility or to long term care. The individual will be transferred back to the care of their own GP with a copy of the discharge summary available to both their GP and the individual themselves.The care home will be responsible for ensuring that the onward transport, discharge summary and required TTO’s have been organised.The provider will be required to welcome East Berkshire CCG and (as require, its partners into the Home at any time should any concerns be raised with East Berkshire CCG in respect of the care and support being provided within the home (for the individuals we place there) so that any required investigation into the allegations can take place.**3.3 Population covered**The population of East Berkshire in 2016 totaled 452,766 people and is characterised by:The number of over 65 years of age is 60,722 (13 %)**3.4 Any acceptance and exclusion criteria and thresholds**Any admissions for individuals outside of these definitions will not be funded by NHS East Berkshire CCG.It is essential that individuals considered by the provider for a short tem bed at the care home are:* Registered with an East Berkshire GP
* Medically stable for discharge from an acute or community hospital bed
* Able to consent and comply with any planned care, treatment or therapeutic intervention

Criteria for individuals to then be considered for admission are as follows:* The individual requires a period of rehabilitation to facilitate return to a level of independence acceptable to them (Discharge to Assess Pathway 2)
* The individual is likely to respond to a period of rehabilitation, but is not yet able to participate (non-weight bearing; Discharge to Assess Pathway 2)
* The individual requires a period of interim care or support before returning to their own home but does not require acute or community hospital provision; this may include ongoing treatment such as the administration of Intravenous Antibiotics within the scope and competency of the providers nursing staff (Discharge to Assess Pathway 2)
* The individual will benefit from a multi-disciplinary assessment to understand the potential required support to meet their longer term health or care needs (local authority or where the individual may require continuing healthcare) in the community.

This may follow a period of rehabilitation or interim care and support (Discharge to Assess Pathway 3).(Other potential reasons for admission may be discussed and agreed with East Berkshire CCG on an individual basis.)The exit plan must also be considered and shared by the referring MDT as part of the referral process.Admission into a short term bed will be for no longer than six weeks and with an anticipated outcome of either 1. rehabilitation / interim care to then facilitate discharge to the individuals home environment

Or 1. all assessments to have been completed and the individuals final destination (own home, residential, nursing home or alternative setting) and support requirements agreed and ready for them to access.

**3.5 Interdependence with other services/providers**The Service is part of the wider adult health and social care services commissioned by East Berkshire CCG and local authorities. The Provider and Commissioner will work in partnership with GPs, Acute and Community Providers, the 3 local authorities - namely Bracknell Forest, Slough Borough and the Royal Borough of Windsor and Maidenhead, Community Mental Health teams, the Voluntary and Community sector, and independent Providers (this is not an exhaustive list).The Provider is expected to be working currently with these and other organisations to support the individual and their carers to successfully manage the individuals' condition/s. The Provider should, as a minimum, have a well-developed pathway for communication with GPs and the wider health, voluntary and social services environment. |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (Care Home with Nursing)**The provider will maintain Care Quality Commission 'Good' registration and adhere to the required standards of Quality and Safety.It is expected that the Provider will ensure that policies, procedures and practices are regularly reviewed and that the following list of standards/good practice guidance is where appropriate adhered to:-* Department of Health (DOH) Guidance as issued
* No Secrets Guidance - Department of Health
* National Institute for Clinical Excellence (NICE) Standards
* DOH Guidance on Infection Control
* The Administration and Control of Medicines in Care Homes - Royal Pharmaceutical Society of Great Britain
* Mental Capacity Act 2005
* Care Act 2014

**Personal Accommodation*** single rooms, with en-suite with disabled access
* disabled facilities for bathing and showering
* enable individuals to have access to their room at any agreed time, and as often as they wish
* have a call alarm system to enable individuals to get help (Fundamental Standard 15)
* not move individuals to alternative accommodation, without prior consent from the individual and the Commissioner (except in an emergency); and

have furniture and fittings appropriate for Individuals including those with physical disabilities* Provision of safe and suitable equipment to support individuals with a range of needs including (but not limited to) risk of falls, bariatric individuals, those at risk of and already suffering pressure area damage

**Visitors*** The Provider will share their visiting guidelines with individuals and any appropriate interested persons on admission.
* Every individual has the right to refuse to see a visitor. The Provider will support this decision.
* The Provider will maintain an individual visitor log

**Advocates**The Provider, will in conjunction with the MDT:* support individual use of advocates;
* make a referral to an independent advocate when a conflict arises in the individual's life and the individual has no relatives or capacity is questioned and relatives do not have power of attorney or the individual is particularly frail or vulnerable. In these instances the Provider will also notify the Commissioner and inform any advocate representing an individual of major changes in the individual's life.

**Individual possessions**The Provider will handle Individuals' money and valuables as per the CQC's Fundamental Standards**Property**Individuals will be permitted to have (within reason), personal property (e.g. pictures, music systems, televisions, and computers) in their room. Individuals and their advocates will be responsible for the maintenance of these items.The Provider will have procedures in place for protecting and securing individuals possessions kept in their own rooms.**In addition**The provider will ensure that care home staff members have appropriate training (statutory, mandatory and other training) as risk assessed by the home, to deliver the service specification requirements.The provider will ensure an appropriate level of staffing to manage the dependency level and turnover of individuals within the care home setting at any one time.**4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)****4.3 Applicable local standards** |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-C)**
	2. **Applicable CQUIN goals (See Schedule 4D)**
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| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:** |
| **7. Individual Service User Placement** |
| The services which are provided will be carried out in accordance with the following philosophy :* To promote the welfare of the individuals receiving the service.
* To respect the human rights of Individuals, rights of personal freedom, choice in daily living, dignity and self-respect, independence, fulfilment, privacy and the exercise of free will.
* To provide assistance to the Individual in relation to frailty, disability or illness in a manner that that reflects the previous two statements.
* To involve the Individual as far as possible in decision- making in relation to their changing needs.
* To keep under review and respond to the changing needs of the Individual in an appropriate way
* To take account of the social, cultural and religious context of the Individual's circumstances when making decisions concerning the individual.
* To use the Individual's own support network whenever possible.

The following values add to the quality of life:* **Privacy** - the rights of an individual to be left alone or undisturbed and free from intrusion or public attention into their affairs.
* **Dignity.** To treat with respect and recognise the intrinsic value of each person regardless of circumstance, respecting their uniqueness and their personal needs.
* **Choice.** Each person to be given the opportunity to select from as wide a range of options as possible.
* **Rights.** The maintenance of all entitlements associated with citizenship.
* **Fulfillment** The realisation of personal aspirations and abilities in all aspects of daily life.
* **Equal opportunities.** It is expected that the service will be provided to all people, irrespective of their race, religion, creed or chosen lifestyle. The Provider should be able to demonstrate that they have a written statement on equal opportunities for staff.
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