# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

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| **Service** | Sutton Intermediate Care Beds |
| **Commissioner Lead** | Sharron Bawden (Head of Transformation) |
| **Commissioner** | South West London Clinical Commissioning Group |
| **Provider Lead** |  |
| **Period** | 1 April 2022 – 31 March 2023 |
| **Date of Review** | November 2022 |

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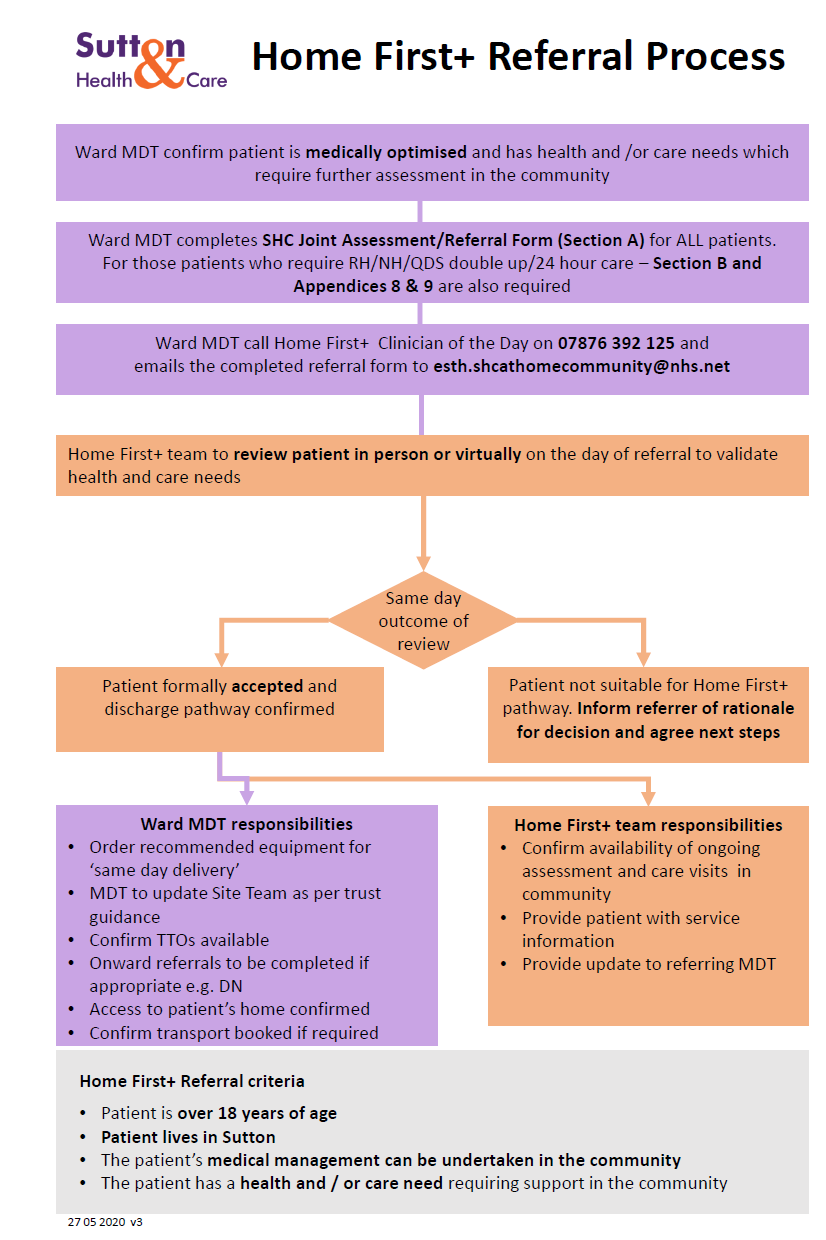
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| Context and Link to Outcomes Frameworks |
| National/local context and evidence base South West London Integrated Care System (SWL ICS), is a collaboration of the NHS, local authorities and other partners across South West London. The ICS is comprised of the organisations providing health and care in the six south west London; Sutton, Merton, Wandsworth, Croydon, Kingston and Richmond. This includes: hospital care GP surgeries, rehabilitation clinics, mental health support, learning disabilities and many others. Within the ICS, Sutton Place ensure that services in Sutton meet the needs of the local population and ensures the most value for patients out of every pound of taxpayers’ investment.  Sutton Place incorporates 23 GP practices, split between 4 or Primary Care Networks(PCNs) serving a population of 180,000 people across the borough of Sutton. Sutton Place along with SWL ICS are responsible for the local NHS budget and making sure it is spent on the right health services for the needs of Sutton residents. Our vision is to commission high quality health care for the people in Sutton through joint working with health and social care organisations to ensure that Service User’s physical, mental and social wellbeing needs are met and can be summed up as “working together to build the best affordable healthcare for Sutton”.  Sutton Place is seeking Care Home Providers, registered for nursing care that will work with Sutton Health and Care (Integrated provider of Community Services in Sutton comprising of Home First + and At Home Teams) to provide nursing care beds for individuals who require 24-hour supervision during their rehabilitation programme and support and to reach their potential for rehabilitation. They will be part of the wider ICS that strives to deliver a service that is Service User focused and delivers on prevention of admission to hospital, clinical effectiveness, outcomes, and supports independence. |
| National NHS Outcomes Framework Domains & Adult Social Care Outcomes Framework:  |  |  | | --- | --- | | Domain 1 | Preventing people from dying prematurely | | Domain 2 | Enhancing quality of life for people with long-term conditions, people with care and support needs | | Domain 3 | Helping people to recover from episodes of ill-health or following injury | | Domain 4 | Ensuring people have a positive experience of care | | Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |
| Scope |
| Aims To provide a responsive Intermediate Care Bed Service to:   * Facilitate early hospital discharge * Prevent admission to acute settings from Emergency Departments and the community * Avoid unnecessary ambulance conveyances * Provide effective clinical nursing management of the Service User supporting and assisting them to meet identified rehabilitation goals * Work with Sutton Health and Care therapists within a maximum period of six weeks, subject to weekly multi-disciplinary review * Be part of a seamless continuum of services linking health promotion, preventative services, primary care, community health services, social care, support for carers and acute hospital care.   The service should provide effective clinical nursing management of the Service User supporting and assisting them to meet identified rehabilitation goals within a maximum period of six weeks, subject to weekly multi-disciplinary review. Objectives  * The Provider will meet all of the Fundamental Standards, with the addition of the details provided in this Service Specification. * The service will receive referrals from Sutton Health and Care Home First+ to prevent hospital admission and support early discharge with timely access to a care home bed between the hours 08:00 – 20:00 7 days a week. Hours of discharge from hospital are generally before tea time, however the requirement for prevention of admission the hours of acceptance must be 08:00 – 20:00, 7 days a week. * Be part of a Multi-Disciplinary Team providing comprehensive in-patient rehabilitation, intermediate care and sub-acute nursing care as appropriate * Provide opportunity for a holistic multi-disciplinary assessment encompassing Service Users physical, medical, social and psychological needs, respecting the individual’s wishes and preferences, with the aim of achieving their potential rehabilitation goals * Involve Service Users at all stages of their care planning so they remain in control of their own lifestyle as far as possible * Provide appropriate help, advice and support for carers * Identify, assess, make recommendations and take actions about any areas of risk * Maximising independence and typically enabling Service Users to resume living at home/ preventing premature admissions to long-term residential care, * Placements are time limited to normally no longer than six weeks, and frequently as little as one to two weeks or less * The Provider will have a workforce that proactively manages the care and therapy needs of the Service User through excellent communications with internal and external professionals * In relation to London Borough of Sutton, the Provider is expected to have a named Social Worker who can support the needs of the Intermediate Care Bed Service Users.  Population covered The registered GP population of Sutton that is eligible for Intermediate Care. Acceptance and exclusion criteria and thresholds Acceptance criteria:   * Medically Stable and Medically Fit for Discharge/Medically Optimised, as determined by the Sutton Health and Care Team. * For supported hospital discharge the Sutton Health and Care Multi-Disciplinary Team will have agreed that rehabilitation can be continued within Intermediate Care. * Service Users must be able to consent and comply with interventions. Where consent is an issue a Mental Capacity Assessment must be carried out before admission to ICS. * Service Users must be engaged and motivated to achieve their rehabilitation goals.   **Exclusion criteria:**   * **Below 18 years of age** * **People with acute nursing/medical needs** * **People who have been identified as not having a planned discharge destination** * **Patients with acute mental health episodes or those who present with an increased risk of harm** * **Patients who require end of life care** |
| Admission to the Provider |
| Admission to the Provider and Requirements on Admission Service users can only be referred and admitted via the Sutton Health and Care Intermediate Care Team and must meet the acceptance/exclusion criteria above.  **Appendix C shows a diagram of the Referral Pathway from Sutton Health and Care to the Provider** Pre-placement assessment  * It is the referrer’s responsibility to ensure that Service Users are admitted to the care home with any individually prescribed equipment. (E.g. Zimmer frame, tripod, wheelchair etc) * Referrers will contact the Provider and provide copies of the relevant assessments as required. * The Provider will confirm acceptance of the Service User within one hour of referral. * If on receiving the referral the Provider identifies complex care needs that need further clarification this should first be investigated via telephone conversation with referrer and in some cases a visual assessment maybe required and must be undertaken within two hours of receiving the referral. * The Provider’s Clinical Team on reviewing the assessment information for admission to the Intermediate Care bed has the right to refuse admission if they do not consider that the nursing home staff have the clinical skills to care for the individual safely in accordance with Fundamental Standard 18 and the Nursing and Midwifery Council, professional accountability. * The Provider’s Clinical Team is responsible for ensuring that the nursing home staff allocated to these residents have the skills to deliver the nursing and rehabilitation care required. * If the Provider assesses that they cannot meet the Service User’s needs, they must act in accordance with Service Condition 7. * If the Provider assesses that they can meet the Service User’s needs then they confirm the admission arrangements with the referrer in one hour if further assessment was not required or three hours if further assessment required. * The therapy needs are assumed as appropriate for Intermediate Care Bed Service, as the patient has been referred from the Sutton Health and Care Team.  Service User’s transfer to Provider care  * Service Users will be transferred to the Intermediate Care Bed Service from an acute hospital environment, or Service User’s own home, between the hours of 08:00 and 22:00 7 days a week – this should be amended to 8-6 weekdays an 8-4 weekends * The Service User will be discharged from acute hospital care in accordance with Fundamental Standard 12.2(i) and Service Condition 11. * The home will liaise with relevant transport companies to quickly facilitate the transfer to the home. At the time of writing, this is Ambulance Solutions. * Service Users will be transferred into the care of the Provider with relevant documentation including the care plan. * Care plan on admission will have therapy and social care needs undertaken by therapist; the Nursing home is responsible for assessing care needs on admission and including nursing care needs into the care plan.  Activity upon admission Within a week of admission, following further therapy assessments a more detailed plan will be agreed clearly identifying the Service User’s rehabilitation goals. This plan will be explained in detail to the Clinical Team named nurse and agreed with Service User. Should the service User (or their NOK) not agree their rehab goals (which may be due to physical limitations, or motivation) then the patient should be rapidly discharged to home with support, enabled by the Sutton Health and Care Team.  As soon as possible after admission a home visit will be carried out with the Service User by the Occupational Therapist to assess the need for any equipment and/or adaptations required to support discharge. These will be included in the discharge plan.   * For admissions from hospital to an Intermediate Care bed, the discharging ward is responsible for finalising with inpatient Consultant, the Service User’s prescribed medication requirements. * It is the responsibility of the Clinical Team receiving the Service User on admission to check that they have all prescribed medication with them on admission. * The medical team discharging the Service User from hospital are responsible for prescribing discharge medication To Take Out (TTO) i.e. medication that the Service User is given to take home once they are discharged; these must be dispensed prior to discharge. * For admissions from the community, the staff organising the admission to an Intermediate Care bed is responsible for ensuring that the Service User has adequate supplies of all prescribed medication, will check current medication with the Service User’s own GP surgery and obtain a repeat prescription where necessary prior to admission. They are also responsible for checking with individual/advocate/NOK if any other over the counter medications are taken regularly. * Service User will be allocated and introduced to their named nurse from the Clinical Team and informed of Key Worker case manager, from Intermediate Care Team * Relatives or NOK will be informed of named nurse and Key Worker and provided with contact details. * Named nurse and Key Worker are responsible for, in conjunction with Service User, developing and agreeing a personalised care plan (including risk assessment) to meet their assessed nursing, social care and rehabilitation needs. * The Care Plan will be agreed with the Service User. This will be one comprehensive individualised care plan that is accessed by all members of the Multi-Disciplinary Team. * Sutton Health and Care team will work with the nursing home staff to ensure that they have the skills and safety awareness to deliver the rehabilitation programme. * Nursing initial assessment to include Waterlow Score, Nutritional Risk Assessment, Wound Care Assessment and Manual Handling.   The Provider will also:   * give the Service User information about the Provider’s services as the Fundamental Standards. |
| Environment, Equipment and Personal Possessions |
| Accommodation Standards and Equipment **4.1.1 General**  The Provider will be expected to:   * maintain CQC registrations for the Care Home; * maintain the Care Home, equipment and daily living adaptations in good working condition in accordance with Fundamental Standard 15; * fundamental standard are listed here: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards> * The Provider will provide the standard equipment (detailed in Appendix A) where required, either through their equipment suppliers or a GP if on FP10, at no additional cost to the Commissioner. * The Provider will maintain equipment as per Fundamental Standards 12 and 15. * If following a clinical review it is identified that the Service User requires equipment not specified in the above list, the Provider must liaise with Sutton Health and Care to discuss purchasing arrangements prior to supply, and this may need to be agreed with the commissioner if it is not within the normal range of Sutton Health and Care equipment.   **4.1.2 Personal accommodation**  The Provider will provide :   * single rooms with en-suite. * Each room to have enough space to manoeuvre a sara steady, walker (therapies equipment). * A room with a hoist * Disabled accessible rooms with en-suite disabled facilities for bathing and showering   would be considered ‘gold standard’   * enable Service Users to have access to their room at any time and as often as they wish; * have a call alarm system to enable Service Users to get help * not move Service Users to alternative accommodation, without prior consent from the Service User and the Commissioner (except in an emergency) * have furniture and fittings appropriate for Service Users including those with physical disabilities * lockable cabinet for self-medication  Therapy spaces  * The Provider will make available adequate space and equipment to provide physiotherapy and occupational therapy to pursue rehabilitation goals. The spaces will be as described below and will be available for use when required by the relevant therapist. * Physiotherapy area ideally 5m x 5m in size to be on same floor as service users’ rooms * Equipment; parallel bars, small staircase, plinth, pedals, lower limb equipment, wall bars for upper limb exercises. This equipment is provided by Sutton Health and Care. Rails on corridor walls may be used as an alternative to parallel bars and this will be provided by the Provider. * Dining room on the same floor as the service users’ rooms that service users are encouraged to walk to and have meals in. * Therapy workstation for administrative work including updating records and telephone calls. Must include a chair and a desk. * Private space for weekly multi-disciplinary team meetings * Occupational Therapy space with kitchen dedicated for patients to complete OT assessments (i.e. not a staff room) including the following equipment supplied by the Provider:   + Worktop for food preparation   + Microwave   + Kettle   + Cutlery/crockery   + Tray   + Kitchen trolley   + Table and chairs (for a minimum of 4 people)   + Fridge  Equipment provided by the Commissioner The Provider must ensure that equipment provided for the Service User by Sutton Health and Care or the Commissioner must be:   * managed safely and securely; * operated in line with the manufacturer’s instructions; * made available for maintenance; and * only used in relation to the named Service User.  Service User possessions The Home will handle Service Users’ money and valuables as per the Fundamental Standards.  **4.4.1**  **Property**   * Service Users will be allowed, within reason as planned maximum length of stay of 6 weeks, personal property (e.g. pictures, music systems, televisions, and computers) in their room. Service Users/their advocates will be responsible for the maintenance of these items. * Providers will have procedures in place for protecting and securing Service Users’ possessions kept in their own rooms. * The Provider’s public liability insurance will cover Service User’s property for theft or damage. This will not apply if damage was caused by the Service User. * The Service User will under no circumstances be required to sign a waiver of liability. * When the Service User is discharged, as agreed with the Sutton Community Health, the Provider will contact the Service User’s next of kin (NOK)/a named representative so they can collect the Service User’s personal effects. Where no NOK/named representative exists the Provider will contact the Commissioner, who will make the necessary arrangements.   **4.4.2 Money**   * The Provider will recognise the Service User’s right to conduct personal finances. * In some cases if the Multi-Disciplinary Team identifies that the Service User requires support with personal finances and there is no NOK, or power of attorney or a Local Authority appointee. Permission to be sought from Service User for referral to Local Authority for support and advice. * The Service User will be expected to pay for the following items (this list is not exhaustive): * Cigarettes and tobacco; Alcoholic beverages; Newspapers and magazines, where specifically ordered by the Service User; Hairdressing; over and above those provided by the Provider, and Clothing and other similar personal items; Toiletries * Personal travel incurred at the Service User’s request (excluding travel relating to the Service User’s care needs); * Optical/ Dental/ Chiropody services (if Service User does not meet the eligibility criteria for NHS treatment); * Legal advice; Holidays; and Social activities not provided by the Home. |
| Staffing Requirements, MDT Working, Access to other Healthcare Services and Visitors & Advocates |
| General staffing, recruitment, training and Service Users’ needs The Provider will:   * have appropriate Staff as detailed in Fundamental Standards 18 and 19 to meet the health and welfare needs of Service Users, and to maintain staff training and receive learning and development opportunities as per Fundamental Standard 18. * maximise Staff continuity and minimise use of temporary staff. * Have appropriate trained staff in enablement in order to provide the therapy interventions in accordance with Sutton Health and Care Intermediate Care Therapy plan. The Provider will provide appropriate levels of suitably trained staff who will be responsible for implementing the agreed care plan and monitoring and recording progress. * 1 RGN on duty dedicated to the intermediate beds * 1 dedicated carer on duty for intermediate beds * Allocation of rehab assistant for the intermediate beds * The Provider will have recruitment practice and policies in line with Fundamental Standard 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. * Staff must be able to deliver care and treatment to meet all Service User safely to an appropriate standard and this must be reviewed on an on-going basis. * In order to meet Service User therapy needs, training will include rehabilitation skills as required in conjunction with Sutton Health and Care Intermediate Care. * All care staff working with Intermediate Care Bed Service Users will be trained to at least NVQ (National Vocational Qualification) level 2 standards and will have received basic First Aid, Manual Handling, Health & Safety, Health & Hygiene, Infection Control, Safeguarding, Fire Safety and Food Hygiene training. Care home staff should also be willing to learn new skills and undertake additional training on rehabilitation techniques which will be provided by the intermediate care nursing and therapy staff. Nursing staff must be a NRN and must be compliant with code of conduct outlined in the Nursing Midwifery Council (NMC). * The Provider will maintain awareness of the Service Users’ needs as outlined in Fundamental Standard 9 informing the Key Worker / Sutton Health and Care Multi Disciplinary Team if any needs are not being met; and * Make Staff clear about their responsibilities and aware of standards as the Fundamental Standards.  Registered nurses Each Service User must have a Named Registered Nurse (NRN). This should ideally be the same RGN for all of the intermediate beds.  The NRN will:   * be responsible for developing, monitoring and updating the Service User’s Care Plan and the delivery of the Sutton Health and Care therapy care plan; * coordinate the care for the Service User as specified in the individualised Care Plan; * participate in the weekly Multi Disciplinary Team (MDT) meetings * develop a professional relationship with the individual and any members of family/friends involved in the individual’s life; and * delegate nursing care provision with an appropriate level of supervision as outlined in Fundamental Standard 18 and in accordance with NMC’s Code of Professional Conduct. * Be competent to administer IV Antibiotics, cannulate and take bloods, where necessary.   For the purposes of continuity each Service User should have a named keyworker on a permanent contract, who will be responsible for liaising with other members of the rehabilitation team and attend the weekly reviews. In order to provide an effective rehabilitation service it is essential that all staff working on the unit understand the philosophy and aims of rehabilitation and are skilled in promoting independence.  Staff are expected to participate in Multi-Disciplinary Team meetings and assessment/treatment sessions. Access to primary and secondary healthcare services Sutton CCG will commission a local GP Practice to provide medical cover for all Service Users admitted to the intermediate care beds through temporary registration with this practice. This medical cover includes a clinical review within 24 hours of admission and thereafter providing medical input and attending multi-disciplinary meetings as appropriate. It is expected that a number of hours of dedicated GP support is organised to support the Intermediate Care Bed service users, and that this may flex according to number of beds occupied. The Clinical Team are responsible for notifying the covering GP on day of admission or next working day (when admitted out of working hours). The care home will fax or email a registration form to the GP and follow up with a phone call.  There must be GP cover for the care home over weekends, and bank holidays.  The service user will be discussed with the Consultant geriatrician/medical ward round once a week and key worker will be required to input into these discussions.  The service users should have access to a dietician and psychiatric assessment/ support, as needed.      Visitors and Advocates  * + 1. **Visitors** * The Provider will share their visiting guidelines with Service Users and any appropriate interested persons on admission, in line with current Infection Prevention and Control / Covid guidelines. * Every Service User has the right to refuse to see a visitor. The Provider will support this decision. * The Provider will maintain a Service User visitor log.   + 1. **Advocates**   The Provider will in conjunction with the Sutton Health and Care Multi-Disciplinary Team:   * Support Service User use of Advocates; * Make a referral to an independent advocate when a conflict arises in the Service User’s life and the Service User has no relatives or is particularly frail or vulnerable. In these instances the Provider will also notify the Commissioner; and * Inform any advocate representing a Service User of major changes in the Service User’s life. * Social worker? |
| 1. **Clinical, Caring, Safeguarding and Policies** |
| Administration, Policies, Contract and Confidentiality  * + 1. **Record keeping** * The Provider will comply with all applicable statutory and legal obligations concerning record keeping and NMC professional standards. * The Provider will comply with all confidentiality requirements detailed in the Particulars and the General Conditions (Service Condition 23, General Condition 20, General Condition 21, and Service Condition 28) regarding personal records for care, treatment and support. * On request the Provider will give the Commissioner any records relating to the provision of the Service. These will be provided to the Commissioner within two weeks of the request being made at no additional cost to the Commissioner. * Develop a system that ensures that the nursing home and Sutton Community Health both have a complete copy of the Service Users records on discharge.   + 1. **Policy requirements** * The Provider must comply with all relevant current legislation and regulations as per Services Conditions 1 – 3, 36 and 37 of the Particulars. * This contract will be assumed to incorporate any changes made to the legislation and its governing bodies.   + 1. **Confidentiality**   A secure network must be used for all electronic communication of Service User identifiable data.  When it is necessary to electronically send Service User identifiable data outside of the Provider organisation then the Provider should use a secure NHS.net email account.  All data obtained by, recorded by or held by the service Provider must be regarded as confidential Service User data and treated in accordance with the Provider organisation Records Management Policy and associated procedures, which must be approved by the Commissioner organisation.   * 1. Risk Assessment and Management   Risk taking is a necessary part of the rehabilitation process. Hazards must be assessed, minimized and controlled as far as reasonably practicable but unless agreed risks are taken progress may not be achieved. Through the process of practicing new skills or re-learning old ones, Service Users will be assisted to maximize their abilities within a controlled environment.  To minimize risks the following points need to be considered by the Provider in delivering the service model:   * Risks must be assessed by a suitably qualified person. * Risk Assessments must be reviewed regularly and revised where necessary. * Service users must be made aware of and be prepared to take calculated risks. * All Staff must receive appropriate training and be aware of emergency procedures. * All staff involved in the care of the Service User must be aware of the potential risks and the risk management procedures that have been put in place. * Manual handling assessments and care needs must be documented and available to all staff caring for the Service User. * Following an individual assessment, appropriate techniques must be demonstrated and practiced with Service Users. * Where identified appropriate equipment will be provided. * Hazards relating to the environment should be considered. * All accidents must be reported in accordance with CQC. * Hazards associated with Service Users achieving personal independence.   Clinical risk is mitigated by a named GP explained in clause 4.7.1 Access to primary healthcare services. The Sutton Health and Care provider will be accountable for the clinical practice of its nursing and therapy staff and they will be covered by that organisation’s governance procedures when delivering care in this service.  The Provider is responsible for providing an information leaflet to the Service Users and their care worker on what they can expect from the service, how to raise complaints and details of their named nurse and Key Worker within 24 hours of admission.  The Multi-Disciplinary Team, if appropriate, will provide the Service User with information on self-management and how to manage a recurrence of their condition.  Clinical meeting such as the Multi-Disciplinary Team will ensure effective cross service communication between all involved in the care of Service Users. Similar internal meetings will ensure handover of on-going Service User care needs, maintain effective oversight of staff, record and monitor on-going functionality of the whole system.   * 1. **Care within the Home**      1. **Service User needs and Provider requirements** * The Provider will assess Service User needs in accordance with Fundamental Standard 9 and Service Condition 10. * The nursing home staff will be part of the Multi-Disciplinary Team and attend the weekly meetings * The Provider is responsible for identifying any changes in the Service Users’ needs and taking appropriate action e.g. Adjusting care plan and informing Key Worker and or GP depending on nature of change using clinical skills and judgement. * The Provider will meet the requirements detailed in Appendix B. The Service User will not have all these needs but where they exist the Provider is expected to meet them. The Provider will work with the Multi-Disciplinary Team to ensure that the Service Users access any other specialist care as appropriate.   + 1. **Comfort Rounds**   The aim of a comfort round is to ensure Service Users are kept as comfortable as possible throughout the day, and their needs attended to in a timely manner.  This ensures continuity of care over any 24-hour period. The round is done by the Healthcare Assistant (HCA) at a minimum of 2 hourly and the needs/interactions with Service User are recorded in agreement. The forms are kept in the folder by the Service Users bed. This is continued during the night and interactions will be on individual needs basis.  The following process should be followed:   * Service User is asked if they require the toilet and assisted as per their care plan. Offered and encouraged to drink and offered something to eat, snacks must be available or encouraged to prepare themselves in accordance with care plan * Asked if they are uncomfortable e.g. pain or discomfort if this is identified reported to Clinical Team for management * Service Users encouraged to stand and move around following their personal therapy plan to encourage rehabilitation and prevent pressure sores, stiffness from sitting in one position for long periods of time. * Ensure their call bell is within reach and that the service User knows where it is   + 1. **Enhanced observation**     2. If a Service User requires enhanced observations during care (exceptional circumstances), the Provider will liaise with the Key Worker, Sutton Community Health Intermediate Care team, to discuss and review care plan which may include seeking Authorisation from the Commissioner for enhanced observation or additional clinical hours this will be supported with written a clinical rationale. In emergencies, where it is not possible to seek advance agreement, i.e. out of hours weekends and bank holidays from the Commissioner, authorisation will be sought the next working day. The Provider will complete an enhanced observation request form provided by the Commissioner to describe the Service User’s clinical condition and demonstrate why enhanced observations are needed. Commissioners may use their own form or they may use the attached example in Schedule 2 part N of the Particulars. The form will be submitted to the Commissioner on a weekly basis (unless a more frequent update is agreed).  Equality and Diversity In compliance with Fundamental Standards 10.2(c) and 13.4(a), and Service Condition 13 the Provider will:   * consider the needs of the Service User in relation to any relevant protected characteristic as defined in section 4 of the Equality Act 2010; and * make reasonable adjustments to make the Services accessible to all disabled people, where applicable as per the Equality Act 2010.  Infection Control **The Provider will:**   * comply with QQC Fundamental Standards: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards> * meet the requirements detailed in NICE quality standard 61: Infection Prevention and Control, April 2014: <https://www.nice.org.uk/guidance/qs61> * The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/400105/code_of_practice_14_Jan_15.pdf> * co-operate with and support screening procedures, in particular Service Users at high risk of contracting healthcare associated infections, e.g. Service Users who will need hospital admissions because of chronic conditions, are going to be having surgery or have pressure sores or leg ulcers; * work and communicate effectively with other organisations to reduce the risk of healthcare associated infections (for instance, when transferring a Service User with MRSA between a hospital and the Home); and * co-operate with the NHS Infection Prevention and Control Nurse and/or the Public Health England (Health Protection Team) to undertake investigation of healthcare associated infections (as required) including post infection reviews (PIRs) and ensure that actions are taken to prevent future occurrences. * follow the latest national, regional and South West London guidance on COVID-19. * make arrangements for family visits (remote or physical) as advised by public health or NHS during COVID surges.  Medication  * The Clinical Team are responsible for ensuring sufficient supplies of prescribed medication for the duration of the stay, obtaining repeat prescriptions as required. * The Provider will be responsible for the safe storage and administration of prescribed medicines for Service Users in accordance with Fundamental Standard 12.2. * The Provider is required to have a medication policy which includes a self-medication in place. * The Clinical Team in conjunction with the Multi-Disciplinary Team are responsible for assessing services users capability for self-administering medication to establish if this forms part of their rehabilitation programme. * Where the Service User is self-administering their medication, a lockable space will be provided for safe storage of medication in the Service User’s room. * On discharge the Multi-Disciplinary Team are responsible for ensuring that the Service User has 2 weeks of TTOs * The Provider is responsible Service User for ensuring that any medication belonging to the Service User is returned to them at the point of discharge as they are Service Users possession or agreeing disposal arrangements with Service User if no longer prescribed medication to prevent confusion with discharge prescribed medication. Where appropriate the Clinical Team will ensure that any oxygen therapy is safely administered in accordance with prescription. * The Provider is required to have a check list incorporating all elements of medicines reconciliation. This must be kept within Service User records.  6.7 Safeguarding and mental capacity The Provider will comply with:   * Care Act 2014 Guidance Section 14 <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1> * London Multiagency Safeguarding  Adults Policy and Procedures (revised 2019) <https://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures/> * Mental Capacity Act(MCA)2005 currently Code of Practice being reviewed currently <https://www.legislation.gov.uk/ukpga/2005/9/contents> <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> * Deprivation of Liberty Safeguards (DoLS)   to be replaced  Liberty Safeguarding Protection(LPS) awaiting guidance <https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance>   The Particulars Schedule 2 Part K contains further details.  All safeguarding issues will be reported to the Commissioner, in addition to the statutory requirement to report all safeguarding issues to CQC and the relevant Local Authority.  Where the Service User lacks mental capacity and has an Appointed Person, the Service User’s decisions and choices will involve the Appointed Person. References to Service User decisions and choices in the Contract will be taken to include Appointed Persons as appropriate.   * 1. **Clinical governance**   The Provider will:   * have a robust system of clinical governance in place as per Fundamental Standard 17; * have a clear, written description of Staff roles and decision-making ability regarding the care of a Service User as per Fundamental Standard 18; and * have a NRN (role as described in Schedule 2, Part A, Clause 4.2.4 (b) of The Particulars). * be responsible for the care that the Service User receives during their stay, ensuring that all identified care needs are met in a safe and timely manner and that the care plan identifies these and how they are met. * be responsible for bringing to the attention of the Commissioner in line with professional accountability, CQC requirements and Safeguarding Vulnerable adults, any concerns they identify in relation to medical and therapy provision that is placing Service Users at risk   + 1. **Care Plan and care record**   Sutton Health and Care are responsible for the rehabilitation programme care plan, agreeing this with the individual and the nursing home staff. There will be one agreed care plan that incorporates the nursing home and Sutton Health and Care’ therapy care plan. Sutton Health and Care Intermediate Care therapists will work with the Clinical Team to ensure that they have the skills and safety awareness to deliver the rehabilitation programme, monitor and record progress towards these goals.  Any difficulties arising should be reported to the therapy team as soon as possible and where necessary appropriate amendments made to the care plan. Overall responsibility for case management will be with Sutton Health and Care’ Intermediate Care Team who will identify a Key Worker who will work closely with the Clinical Team named nurse.  The Sutton Health and Care Intermediate Care therapist will ensure that on admission to an Intermediate care bed, that a copy of the Service User’s assessment documentation including an initial care plan outlining the main rehabilitation goals and a provisional discharge plan.   * The Care Plan is an assessment of the Service Users’ needs, planning to meet those needs, implementing the plan and reviewing and recording those plans. * Wherever possible the Service User shall be given a copy of the Care Plan in their preferred language by their NRN. * The care record is a record of health and care that a Service User receives. * The Home must maintain a nursing care record, which details, in English, all the nursing care provided to a Service User to confirm that the Care Plan has been implemented. This record must be standardised and include, but not be limited to: * Contemporaneous recording * the date and time care was provided; * the type and frequency of care provided; * observations which may be relevant to nursing need; * action to be taken and the name of the person responsible; and * if written documentation is used provide a list of names of all Staff members providing the care at the front of the care plan.   + 1. **Coordination with CQC and Local Authorities**   Where possible Commissioners will work with CQC and Local Authorities regarding contract monitoring to avoid duplication.   * 1. **Access to NHS secondary and tertiary care services**      1. **Outpatient Appointments**   The Provider will assist the Service User to attend any hospital outpatient appointments that may be required during their stay.  The Provider will enable Service Users to access the full range of primary healthcare services via their GP.  The Provider will refer Service Users to the GP managing these services in a timely manner.  Primary healthcare Providers are expected to deliver their services. If they do not provide the services, this should be raised with the Commissioner who will work with primary healthcare Providers and the Provider to resolve it.   * + 1. **Transport** * The Key Worker/Clinical Team are responsible for identifying and agreeing who is responsible for arranging transport for Service Users attending secondary and tertiary care service appointments. * They are responsible for liaising with the appointment Provider regarding return transportation, informing the individual of the arrangements. * The cost of transport for NHS-related appointments (including home visits and discharge) will be funded by the NHS. * For non-NHS related appointments, the cost of transport will not be funded by the NHS.   + 1. **Accompaniment** * The Provider will ensure the Service User is accompanied appropriately to the level of risk and care need associated with the appointment. * The first four hours of escorting will not be charged as an additional cost to the Commissioner. Provider escorting required beyond the first four hours will be charged at the hourly enhanced observation rate outlined in Schedule 3, part A of this Service Specification. * In the case of hospital admission, the Service User will remain accompanied up until the point of admission.   + 1. **Communication**   The Clinical Team will alert the appointment Provider of any Service User interpretation and communication requirements prior to the appointment. |
| 1. **Hospital Stays and Termination of an Intermediate Care Bed Placement** |
| * 1. **Hospital stays**       1. **General principles**   The Service User’s placement with the Provider will remain open for up to 8 hours in discussions with Sutton Health and Care ICS.   * + 1. **Activity supporting Service User admission into hospital**   Upon admission into hospital Provider will inform:  the Service User’s NOK/a named representative as soon as possible.   * the Key Worker within 2 hours during working hours or out of hours by 9 am the following day, the nominated GP within 2 hours during working hours or by 9 am the following working day. * Once confirmation is received that Service User is to be admitted for inpatient care, the Service User is discharged from the Intermediate Care Bed service and would require a new referral if this service were required on discharge.   + 1. **Activity supporting Service User discharge from hospital**   Prior to the Service User’s discharge from hospital the Key Worker will provide an update to the Provider on the Service User’s clinical needs to ensure they can be met by the Provider.  If the Provider can continue to meet the Service User’s needs, the Provider will confirm to the Sutton Community Health Intermediate Care Key Worker of the re-admission verbally/email/in writing within 24 hours:   * any revisions to the Care Plan will be discussed with the Key Worker within 24 hours of re-admission; and * the Service User’s NOK/a named representative will be informed of the re-admission as soon as possible.   In exceptional circumstances where the Provider can no longer meet the clinical needs of the Service User (Service Condition 7), the Provider will notify the Key Worker as soon as possible explaining the rationale for no longer being able to care for the Service User.   * 1. **Absence**      1. **Planned trips (less than one day) without Provider Staff** * A Service User may take a planned trip and go out of the home (for instance, with family and friends). * On these occasions the Key Worker needs to be informed and a risk assessment completed in conjunction with the Service User (and the person or persons accompanying them) prior to the outing. The risk assessment shall address the care the Service User should receive (including timely administration of medication) and when the Service User is due to return to the Home. * A person may not be deprived of their liberty unless under Deprivation of Liberty Safeguards (DOLS) as set out in the Mental Capacity Act 2005.   + 1. **Self-discharge**   Should a Service User wish to discharge themselves from the Intermediate Care bed service:   * It is the Clinical Team /Key Workers responsibility to try to establish why this is the case and undertake risk assessment * Explain that the GP will need to be informed * Discuss with Multi-Disciplinary Team and establish if safe discharge is achievable and agree management plan either to support continued admission or self-discharge * Inform Service User of outcome of discussion and proposed plan to manage Service User’s reasons for self-discharge * If Service User insists on self-discharge the Clinical Team will activate agreed self-discharge plan and seek permission to inform NOK/Advocate and seek agreement to arrange care package to support self-discharge * Inform Sutton Health and Care Multi-Disciplinary Team of Service User’s plans * If self-discharge to go ahead Service User to sign self-discharge form and inform Service User’s own GP of intentions and plans in place to support. * Confirm outcome to Multi-Disciplinary Team.   + 1. **Unplanned absence/ absconsion** * If a Service User does not return to the Home as planned following agreed leave, the Clinical Team will try to contact the Service User and those accompanying them to establish if there is a problem. If the Service User cannot be contacted, the Clinical Team should instigate escalation procedures based on the risk assessment, which could include first contacting Key Worker and Commissioner to agree next steps which could include raising a safeguarding alert and calling the police. * If the Service User leaves the Home without notifying the Clinical Team, the Provider should instigate escalation procedures based on the risk assessment, which could include calling the police and raising a safeguarding alert. * The Provider will notify the Commissioner of the unplanned absence within 24 hours. * The Provider will adhere to the reporting requirement for Service Users receiving care under any section of the Mental Health act as appropriate.   1. **Discharge from the Provider / Eviction**   Discharge arrangements will be coordinated by the Service User’s Key Worker who will ensure that these arrangements are planned, agreed and communicated to all relevant agencies and persons involved in delivering care to the Service User.  Discharges from Intermediate Care Beds should be managed to allow the room to be vacated, cleaned and ready to accept a new admission from 16.00 unless a deep clean is required.   * Service Users will be discharged in accordance with Service Condition 11. * Service Users will not be discharged without prior approval from the Multi-Disciplinary Team and in agreement with Service User NOK/advocate. * The Provider is responsible for detailing a ‘Discharge Summary’ to the Service User’s registered GP. * If Therapy input ceases at the same time as discharge from the Provider then the Therapy Lead from Sutton Health and Care is expected to submit a Therapies Discharge Summary on their Therapies system and a copy will be sent to the Service User’s GP. * All reasonable efforts will be made to prevent Service User eviction from the intermediate Care Bed. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Eviction will only occur if all other demonstrable efforts to resolve issues have been unsuccessful. * If, despite all reasonable endeavours to resolve issues, the Provider cannot meet the needs of the Service User then the Provider and Commissioner will work to discharge the Service User to a service that can meet their needs.   1. **Death**   In the event of the death of a Service User, the Provider will comply with Service Condition 34 and the Fundamental Standards. The Provider will also notify:   * Sutton Health and Care’ Key Worker and the Commissioner verbally/email/in writing within 24 hours. * the Service User’s GP within 24 hours; and * the Service User’s NOK/a named representative as soon as is reasonably practicable, so that suitable arrangements (including burial/cremation) can be made.   The Provider will provide the Service User’s NOK/named representative with a quiet room where they can sit and grieve when the Service User has died.  The Provider will ensure that the Service User’s medicines are managed in accordance with the Fundamental Standards.  In the cases of a suspicious death the Provider will notify the Commissioner as soon as is reasonably practicable. |
| 1. **Complaints and Feedback** |
| * 1. **Complaints and Feedback** * Complaints, concerns and suggestions should be viewed as a means of improving service quality. * Providers will effectively manage complaints as guided in Fundamental Standard 16. * In the event of a formal complaint the Provider will notify the Commissioner if the Provider is unable to resolve the complaint to the complainant’s satisfaction using the Provider’s complaints procedure. * The Provider should include the NHS Friends and Family Test within their feedback questionnaire which should both be given to all Intermediate Care Bed patients. This allows the NHS to contribute to National Friends and Family Test data. * Complaints related to Sutton Health and Care provision can be made via the Epsom and St Helier Trust Patient Advise and Liaison Service (PALS).   1. **Raising concerns** * The Provider shall deal with Staff concerns about the Services as per Fundamental Standard 16. * The Provider is responsible for bring to the attention of the Commissioner any concerns they identify in relation to medical and therapy provision that is placing Service Users at risk |
| 1. **Applicable Standards** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-D)**   2. **Applicable CQUIN goals (See Schedule 4E)** |
| 1. **Location of Provider Premises** |
| **The Provider’s Premises are located at:** |
| 1. **Appendices** |
| **Appendix A Standard equipment to be provided by the Provider**  **Appendix B: Service User needs and requirements of Provider (non-exhaustive)**  **Appendix C: Sutton Health and Care Referral Process from Hospital to Provider** |

**Appendix A Standard equipment to be provided by the Provider**

| Category | Equipment |
| --- | --- |
| Moving & Handling | * Height-adjustable profiling beds * Bed-rails and bumpers * Over-bed trolley table * Hoist – sling, standing * Slings – one pair per Service User * Hoist scales * Slide sheets – one per Service User * Handling belt * Bath equipment – bath hoist, shower chair * Sliding boards * Turn tables * Rota stand/sara steady – to be ordered by SHC staff |
| Mobility | * Transit wheelchairs * 1 x standard wheelchair * 1 x tilt in space wheelchair * Grab rails |
| Seating | * Variety of chairs to meet individual needs and promote Service User independence including high riser chair |
| Skin | * Mattress – soft foam, high pressure relief and low air loss mattresses (up to grade four pressure sore management) * Cushions – pressure relieving |
| Elimination | * Commode/commode chair * Bed pans * Urinals * Raised toilet seats * Stoma Bags, wipes and skincare products * Catheters * Catheter Care including tube and bag * Disposable gloves and aprons   Disposable wipes and tissues and other cleaning materials (e.g. hand gel)   * Access to incontinence products appropriate to Service User (if in receipt of incontinence products at home supplies need to be bought in from home for use) |
| Respiratory Support | * Nebulisers   + Filters   + Mask and tubing * Catheters (Yankauer) * Oxygen mask and tubing * Basic resuscitation trolley |
| Assistive technology | * Communication aids/signs to assist Service Users with hearing/visual/cognitive impairments   Call systems with an accessible alarm |
| Nutrition – food and drink | * Adaptive cutlery and crockery * Non-slip mats |
| Nursing care | * Blood glucose monitors * Body spillage kits * Weighing scales |

**Appendix B: Service User needs and requirements of Provider (non-exhaustive)**

| Need | Requirements |
| --- | --- |
| * Behaviour (consequence of delirium) * passive non-aggressive behaviour * Some resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance) * fluctuations in mental state * frustration associated with communication difficulties and self-care abilities and healthcare needs due to illness | * Support behaviour, in particular: * Provide clear information in relation to why treatment is required * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management. |
| * Cognition * short term memory issues related to acute illness * Disorientation to time and place due to illness * making basic decisions | * Encourage Service User’s family/friends to visit and bring in Service User’s personal possessions (for instance, photographs). * Use reality orientation and validation techniques. * communication strategy to assist Service Users to express needs and make decisions. * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Psychological and Emotional needs * Anxiety * reluctance to engage in daily activities | * Motivate towards engagement with daily activities. * Provide additional support to facilitate Service User involvement as required. * Support Service User with life changing events as required in accordance with the Fundamental Standards. * Support Service Users’ relationships (including partners, families, and friends) as per the Fundamental Standards. * Have an activity programme tailored to meet the Service User’s needs and prevent isolation as per the Fundamental Standards. * Care Staff have knowledge and skills required to manage these care needs. * Care plan reflects management plan appropriate to these needs and the management. |
| * Communication (relates to difficulty with expression and understanding, not with the interpretation of language) | * Communicate with Service Users as per the Fundamental Standards. |
| * Mobility * Unable to consistently weight bear * Completely unable to weight bear * High risk of falls * Needs careful positioning * restricted assistance to or cooperate with transfers and/or repositioning * rehabilitation programme | * Have falls and moving and handling risk assessment and prevention strategies. * Staff must be trained in moving and handling and falls prevention. * Provide and maintain mobility equipment[[1]](#footnote-2). Replace where necessary. * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Nutrition – food & drink * Poor appetite due to acute illness reluctance to eat and drink * weight loss or gain * Non-problematic/ Problematic PEG | * Support the Service User’s nutritional requirements in line with Fundamental Standard 14. * Staff must be familiar with nutritional assessment tools and use appropriately. * Seek GP/dietician advice when a significant change in weight occurs. * Skilled intervention to ensure adequate nutrition/hydration. * Manage use of PEG feeds (seeking specialist advice as appropriate). * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Continence * Incontinent of urine and/or faeces * Catheterised * Requiring stoma care * Chronic urinary tract infections | * Recognize normal patterns and act on abnormal occurrences (seeking specialist advice as required). Monitor for and act on any infection. * Have appropriate management supervision and equipment (for instance, in relation to catheterization, bowel management). * Have appropriate training in catheter and stoma care. * Undertake continence assessments and promote continence with individual continence programs * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Skin (including tissue viability) - a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin. * Skin condition that requires monitoring or re-assessment. * Risk of skin breakdown requiring intervention. * Pressure damage or open wound * Open wound, pressure ulcer with full thickness skin loss and necrosis extending to underlying bone. | * Have policies and procedures that comply with current NICE guidance and best practice guidance. * Train Staff to promptly recognize and act on changes to risk factors as per the Fundamental Standards. * Have equipment to maintain skin integrity[[2]](#footnote-3). * Manage skin conditions. * Have evidence-based wound management policy that meets local tissue viability referral criteria. * Have a nominated tissue viability link nurse for each home who undertakes training in wound care to recognize problems as they occur and seek specialist advice. * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Breathing * Shortness of breath which may require the use of inhalers or nebuliser * Episodes of breathlessness that do not respond to management * Require low level oxygen therapy. * Requires CPAP (continuous positive airways pressure) ( exceptional circumstances) * Breathing independently through a tracheostomy( exceptional circumstances) * Tracheostomy suction to maintain airway ( exceptional circumstances) | * Staff must be trained to use equipment and oxygen to support Service User breathing as prescribed (for instance, nebulisers, CPAP and tracheostomy equipment). * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Drug therapies and medication * Requires supervision and administration and/or prompting * Self-medication * Non-concordance or non-compliance * Administration of complex medication * Medication via PEG * Requires on-going pain control * EOLC (including Controlled Drugs) (exceptional circumstances) | * Manage medicines in accordance NICE guidance. * Monitor fluctuating conditions and managing side effects. * Have a written procedure for medicine management, including self-medication which includes managing non-concordance and non-compliance. * Undertake self-medication assessments, including risk assessments with Key Worker * medication reviews as required. * Use a range of methods to assess pain. * Administer analgesia as prescribed and monitor effect using pain assessment tool. * Use non-pharmacological methods to reduce pain and discomfort. * Manage medication for deteriorating or changing conditions * Have a system to prescribe (and store in the home) anticipatory end of life drugs. * Staff must be trained in administering complex medication including via PEG * Staff are trained in the use of syringe drivers * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * Altered states of consciousness – can include a range of conditions including stroke and epilepsy. | * Undertake and regularly review risk assessments. * Implement individualised epilepsy management plans. * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |
| * End of life care (exceptional circumstances) | * Involve Service Users and their family/friends (as appropriate) in planning for their EOLC (end of life care) as per the Fundamental Standards. * Act in accordance with a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status if this has been recorded in the Service User’s medical notes. * Offer Advance Care Plans (ACPs) to Service Users at appropriate intervals. Review ACPs as required. * Train all Staff in end of life identification, planning and coordination skills in line with a model such as the Gold Standards Framework. * Manage Service User care in final days of life. * Manage care in line with the “NICE quality standard for end of life for adults”. * Develop links with community palliative care team. * Care Staff have knowledge and skills required to manage these care needs * Care plan reflects management plan appropriate to these needs and the management |

**Appendix C: Sutton Health and Care Referral Process from Hospital to Provider**

1. [↑](#footnote-ref-2)
2. [↑](#footnote-ref-3)