SCHEDULE 2 – THE SERVICES

A. Service Specifications

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

All subheadings for local determination and agreement

Service Specification No.	
Service	COMMUNITY BASED INTERMEDIATE CARE SERVICE
Commissioner Lead	Bracknell Forest Council and Bracknell and Ascot Clinical Commissioning Group
Provider Lead	Bracknell Forest Council and Berkshire Health Foundation Trust
Period	April 2017
Date of Review	March 2018

1. Population Needs

1.1. National/local context and evidence base

1.1.1. Nationally 29% of the population has one or more long-term conditions (LTC). Statistically they use 50% of GP appointments, 65% of outpatient appointments, and 70% of bed days. By 2025 42% more people will be over 65, and18million people will have one or more LTC. In East Berkshire 41% of the registered population have one or more LTC. In 2011 there were 12,458 non-elective LTC admissions, 54% of these patients stayed for 15+ days. 61% were aged 65+ and used approximately 236 inpatient beds.

1.1.2. A recent audit by NHS Benchmarking showed that while only 5 per cent of people aged over 65 who are admitted to hospital stay for more than 21 days. That 5 per cent accounts for more than 40 per cent of all bed days. Therefore, there remains a need to facilitate patient discharge from acute care and support them in a community setting.

1.1.3. It was calculated in the National Audit of Intermediate Care (NAIC) 2012 that intermediate care capacity needs to approximately double to meet potential demand. However, as in NAIC 2013 and NAIC 2014, there is no evidence in NAIC 2015 of a material increase in capacity. Locally, no increase in funding is anticipated so more effective use of current resources must be demonstrated to increase local capacity. It is recognised that 7 day services are essential if intermediate care is to make an impact on admission avoidance.

1.1.4. Nationally the average waiting times reported at the service level have shown a deteriorating trend over the last three years across all intermediate care service categories which may be a symptom of demand continuing to outstrip capacity.

1.1.5. The trends above are rising and so it is important to identify individuals at risk of non-elective admission to acute hospital. Patients need to be supported in a community setting to avoid potential admission; and if admitted, identified upon entry into hospital, then supported for early discharge to their place of residence.

1.2. Local Context

1.2.1. Bracknell Forest Council and Bracknell and Ascot CCG are working to jointly commission and integrate services. This ensures that the social care and healthcare needs of individuals are assessed and met within a holistic approach.

1.2.2. Intermediate Care is funded by Bracknell Forest Council and Bracknell and Ascot CCG through a section 75 (pooled budget) agreement as part of the Better Care Fund.

1.2.3. In response to recent changes surrounding the provision and status of intermediate care bed based facilities an options appraisal was requested by the Better Care Fund Steering Group. The key drivers for the options appraisal were:

- Changes to local community based services, including those commissioned by the NHS, have increased, in response to peoples' needs and national policy including the "NHS 5 Year Forward View" and the Better Care Fund - and will continue to do so.
- The withdrawal of nursing services from the bed based unit at the Bridgewell Centre in March 2016, and the subsequent re-registration of the centre's status with the Care Quality Commission as "Residential" rather than "Nursing" provides the opportunity to review the future options for provision of Intermediate Care, having regard to changing local demand and Government strategy.
- A decision not to relocate the current facility from the existing location at Ladybank to the "Denis Pilcher" site, due to significantly increased capital costs associated with building adaptations that would be likely incurred, should such a move take place.
- Requirements identified within the Intermediate Care Joint Commissioning Strategy and the outcomes of the Better Care Fund programme of work.

1.2.4. The options appraisal was discussed at the Better Care Fund Steering Group on the 18th July 2016. The preferred option was to decommission the current bed based intermediate care service, at the Bridgewell, and commission a community based intermediate care service.

2. Outcomes

2.1. NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term**	**X**

	conditions	
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. **New Vision of Care**

2.2.1. The service matches well with the New Vision of Care:

- Co-produced with local people and professionals.
- Partners act beyond organisation boundaries and aspire to standardise procedures and shared risk.
- Multi-skilled team making best use of strengths across the system.
- Aims to make use of appropriate technological enablement.
- Actively engaging with people and carers to prioritise their goals.
- Simplifies the user journey so that the right thing to do is the easy thing to do.

2.3. Local defined outcomes

2.3.1. The expected outcomes for individuals using the service are:

- Prevention, improvement, maintenance or management of their decline in independence, health and wellbeing.
- Maximise their ability to live independently.
- Avoidance of unnecessary hospital admission.
- Being in hospital no longer than is necessary.
- Avoidance of premature admission to long term residential care.
- Have a positive experience of care.

3. Scope

3.1. Aims and objectives of service

3.1.1. The overarching aims of intermediate care and this service are to:

- Enable adults (aged 18+) to improve, maintain or manage changes in

levels of independence, health and wellbeing, through a process of care, re-ablement or recuperation.

- A multi-disciplinary decision making approach providing a person-centred service collaborated care between primary care, adult social care and voluntary sector.

- Achieve better outcomes for people to remain independent and in their own homes for as long as possible.

- Prevent avoidable hospital admissions and attendances through the provision of community based care pathways allowing patients to be seamlessly step up or down levels of care/support.

- Support the early transition from hospital for rehabilitation in the community or an individual's own home.

- Reduce the instances of premature entry into long term care.

- Deliver services in partnership with health and social care, forming multidisciplinary integrated teams; including support staff, therapists, social workers, mental health, medical practitioners and nurses and the falls service.

- Deliver timely, cost effective, efficient services that meet an individual's needs.

3.2. Service description/care pathway

3.2.1. The service utilises the following terms:

- **Rehabilitation**: An active process by which those disabled by injury/disease achieve a full recovery, or if full recovery is not possible, realise their optimal physical, mental and social potential and are integrated into their most appropriate environment. Rehabilitation is goal orientated and involves a mixture of clinical, therapeutic, social and environmental interventions.

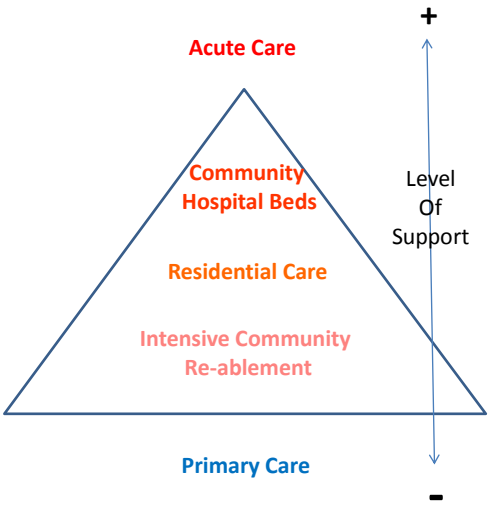
- **Enablement**: Helping people become more independent and improve their quality of life both inside and outside their own home in order to help them get home and stay there. It gives adults the opportunity and confidence to relearn and regain some of the skills they may have lost because of poor health, disability or impairment or after a spell in hospital or problems at home.

- **Reablement**: Relearning the skills necessary for daily living following illness, usually with guidance and support from health professionals, so that there is an improvement in function and increased independence.

3.2.2. The Community Based Intermediate Care service supports individuals, in a community setting, offering levels of care below that provided in an acute hospital but above that provided in primary care. It offers the ability to step individuals up or down different levels of care and support, making use of existing networks/pathways and infrastructure. Importantly, it integrates health and social care throughout the hospital admission and hospital discharge pathways.

3.2.3. An illustrative model of the Community Based Intermediate Care support triangle is show below:

Conceptual Model of Community Based Intermediate Care



Location	Services
Frimley Park Hospital	Acute 24/7 hospital care
Wokingham Maidenhead Windsor	Nurse led community hospital beds – bed based nursing 24/7
Local Economy	Contracted beds supported in by MTD teams provides 24/7 care
Patient's home in community	Multi-disciplinary (MTD) teams of health and social care providing intensive care and re-ablement 8am - 10pm, 7 days a week
Primary Care	GP led including OOH, Community nursing teams, Integrated Care Teams (ICT) Home Care Packages 8-8 , Falls and Re-ablement, Falls Free 4 Life, Rapid Assessment Community Clinic, Urgent Care Centre

3.2.4. Referral criteria for hospital and nursing/care home admission avoidance are discussed later.

3.2.5. "That an End of Life Care service will be provided by the ICS scheme, to enhance the patient experience by accelerating access to care and support for CHC fast track patience. The capacity within the service can accommodate up to 5 people at any one time. The end of life care provided by the service will cover both the CCG statutory duties under the CHC framework, and the local authority statutory duties to provide Care and support under the Care Act. The funding for the service is apportioned to commissioners in line with these statutory duties".

3.2.6. Individuals will be identified for early discharge from acute hospital by an integrated (health and social care) team working in conjunction with the hospital staff to jointly identify suitable patients who are either medically stable or medically fit for discharge. The team would jointly plan the person's early supported discharge from hospital allowing them to return to a community setting to continue their care and rehabilitation. Ideally this should be done as close to admission to hospital as possible.

3.2.7. The service undertakes an holistic assessment of the person, environment and support available in order to address the individual care requirements and to prevent avoidable future crisis.

3.2.8. Patients will be triaged into one of following support levels in the community:

- **High level** of support need: This provides support offering patients 24/7 medical support, below the levels offered in acute hospitals. Where possible this will be local to the patient's place of residence.

- **Medium level** of support need: This provides support offering individuals

24/7 care. This would support individuals where their place of residence is unsuitable for the care required or where 24 hour support is required.

- **Medium / Low level** of support need: This provides support in an individual's place of residence. This would provide care and support from 8am to10 pm, 7 days a week; and where required supportive technology and on call support would provide additional reassurance during the silent hours.

3.2.9. Each level of support would provide intensive person centred care, rehabilitation and reablement allowing the person to recover and regain their ability to support themselves; thus allowing them to be quickly discharged back into primary care for their on-going / long term care and support.

3.2.10. The provider is encouraged to engage with the voluntary sector to provide enablement in order to promote independence and the improve quality of life of those using the service.

3.2.11. People using the service are to be reviewed regularly as part of the multi-disciplinary approach and then seamlessly stepped up or down the support triangle. Following achievement of their established goals and where individuals are deemed to no longer require intensive community care and rehabilitation, the service user will discharged back to the GP as the primary clinician.

3.2.12. Discharges will be communicated between the service and primary care staff. The communication includes a concise electronic summary of the clinical and social care interventions delivered, the outcomes, progress against agreed goals and future care requirements.

3.2.13. All discharge reporting will be completed within one working day following patient discharge and communicated to the receiving services.

3.2.14. Upon discharge from the service, ongoing care would be undertaken by the local community resources which are (but not limited to):

- Rehabilitation and reablement services - provided by Adult Social Care and the Falls Service and long term residential care.
- Medical services provided by GPs, and community nursing teams.
- Urgent Care Centre and Out of Hours Services.
- Services provided by BHFT including the RACC/ARC, specialist clinics such as: Management of neurological conditions including Multiple Sclerosis, Parkinson's and Stroke Care, Heart failure nursing, Continence nursing, Respiratory specialist nursing, Tissue viability nursing, End of life care, Speech and language therapists, Community Rehabilitation.
- Care management and review by the Primary Care Integrated Care Teams supported by the patient's GP.
- The Voluntary Sector would provide support to help people integrate into their community during and after periods of re-ablement and care.

3.2.15. The service would be expected to liaise with primary care integrated care teams (ICTs) and where applicable attend multidisciplinary meetings, to ensure care is seamless continued. Where necessary, individuals are to be

'consented' for cluster review prior to discharge into primary care.

3.2.16. The service will engage fully with the development of new technology for the improvement of efficiency and patient outcomes. It will utilise new technology and telehealth to:

- Maximise efficiency, enabling health care professionals to care for a larger caseload remotely and reducing wasted time and resources.
- Provide access to remote advice, monitoring and treatment providing the timeliest care possible.
- Facilitate access to remote advice from other health care professionals and specialists to support the provision of high quality care.
- Maintain patient independence, improve health outcomes and prevent admission to hospital.
- Empower individuals to manage their own health and wellbeing without delaying access to health and care services as the need arises.

3.3. Capacity Planning

3.3.1. National Benchmarking for Intermediate Care 2015 stated that the national average for intermediate care was 25.6 beds per 100,000 population. Assuming Bracknell Forest population is circa 113,000 (source 2011 census) this represents a national average requirement of 30 beds.

3.3.2. Benchmarking identified in the options appraisal concluded that 20% of people have high need, 40% have middle needs and 40% of people have low needs, for rehabilitation and care. An indication of the service capacity is estimated below, however, capability and capacity need to be reviewed and balanced throughout the life of the contract:

- High dependency = 6 beds
- Medium dependency = 12 beds
- Low dependency = 12 beds

3.3.3. The commissioner would wish to review the service capacity verses demand with the provider, at least annually, at the service contract review meetings.

3.3.4. Historically commissioners have looked at beds but moving forward the service should define a range of interventions capable of meeting the demand and define how pooled resources will be managed to meet fluctuations at each level of dependency.

3.3.5. The service will measure the overall demand (referrals for admission avoidance and supported discharges) and the service's ability to accept, treat and successfully discharge, within the parameters of the specification. Partnership working and the use of local pathways will be key to managing the demand and key for maintaining the quality of care.

3.4. **Referral**

3.4.1. People appropriate for the service will be identified through the following avenues:

- Patients own GP.
- NHS 111 and Out of Hours Services.
- Clinical referral from community nursing services.
- South Central Ambulance Service.
- Acute Trust Clinician.
- Urgent Care Centre and Walk-in Centres.
- Primary Care Integrated Care Teams.
- Falls Services.
- Adults Social Services, notably intermediate care.

3.4.2. The initial point of referral for the service will be via a central hub providing:

- A single point of access for all referrals.
- Triage of referrals, through a common assessment process, within 2 hours of receipt.
- Appropriate advice/guidance to referrers.
- Appropriate appointments and referrals based upon individual patient and referrer needs.
- An out of hours facility for capturing referrals outside of service operating hours.
- Acknowledgement of all referrals and service feedback of the user experience.

3.5. Population covered

3.5.1. The population of Bracknell and Ascot registered with a Bracknell and Ascot GP. Noting: Ascot patients would require support from their own social service provider dependent upon their place of residence.

3.6. Any acceptance and exclusion criteria and thresholds

3.6.1. Individuals must meet the following criteria to be eligible for this service:

- Any person that is not managing their own health or social care needs and is at risk of admission to hospital or residential/nursing care.
- Any person identified as requiring supported discharge from local acute hospitals.
- People that are frequent emergency department or residential care admissions and have multiple GP visits / social care contacts.
- People who are at high risk of falling and frequent fallers.

- People that would benefit from short term monitoring due to an exacerbation of an existing medical condition.

3.7. Proposed Exclusion Criteria:

- People under 18 years.
- People who do not meet the eligibility criteria.
- People whose needs cannot be met and managed in a community setting.

3.8. Interdependence with other services/providers

3.8.1. The service should engage with all stakeholders supporting the Admissions Avoidance, Supported Discharge, Frail and Elderly and Long Term Conditions pathways this may include:

- South Central Ambulance Service.
- Social Services including: Intermediate care and Falls Services.
- Acute Care Providers.
- Community Services including: Nursing, dieticians, podiatry, physiotherapy etc
- Primary Care Providers.
- General Practitioners.
- Primary Care Integrated Care Teams for people with Long Term Conditions.
- Service users and carers.
- Third Sector organisations/groups.
- Commissioners / other Better Care Fund projects.
- Out of Hours care providers.
- Urgent care providers.

3.8.2. Close collaborative working with the adult social care teams (Bracknell Forest, Royal Borough of Windsor and Maidenhead and Slough) will be required. Integration with Frail and Elderly pathways and the local Falls Programme(s) will be necessary. Collaboration will be required with other local initiatives and those projects (relating to the Complex Case Management, Frailty and Falls) developed by the Commissioners during the life of the contract.

4. Applicable Service Standards

4.1. Applicable national standards (eg NICE)

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

Royal Colleges)

4.3. Applicable local standards

4.3.1. The patient's GP will receive notification (a triage report) and the outcomes (Management Plan) that one of their patients has been reviewed and/or treated by the service.

4.3.2. During operational hours each referral is to be responded to and triaged within 2 hours, and a management plan is negotiated between the service, referrer, referee and/or next of kin.

4.3.3. Those patients requiring community hospitalisation, referrals will be responded to and admission arranged on a same day basis, within 4 hours, whenever a bed is available.

4.3.4. Following triage, those patients considered most at imminent risk of hospital admission and accepted for the service, are to be offered same day support or within 24hours of triage.

4.3.5. For those patients considered not at imminent risk of hospital admission and deemed appropriate for the service then an assessment will be undertaken between 48 and 72 hours.

4.3.6. Intensive community care and rehabilitation which is provided from 8am to 10pm, 7 days a week. Where deemed appropriate telehealth/telecare will be used to support individuals during the silent hours.

4.3.7. The service will ensure robust data collection processes are in place to record relevant data defined in the specification. These will be communicated with the Commissioner as detailed.

4.3.8. Within 24 hours of discharge from the service, effective written communication is to be fed back to Primary Care and to other partners associated with the individual's on-going care. Where applicable a management plan will agreed with the patient and the care co-ordinator to help with self-care and prevention. Management plans will be shared with those involved in the individual's on-going care.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement