SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	02/GMS/0022
Service	BP Acute Care Closer to Home Service – Intermediate Care Service
Commissioner Lead	CCP for General Medical & Surgical
Provider Lead	
Period	2013/14
Date of Review	To be Agreed

NHS Outcomes Framework Domains & Indicators

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

1. Purpose

1.1 Aims

To provide a locality integrated health and social care multi-professional Acute care closer to home/intermediate care services intermediate care service for all adults over the age of 18 who are registered with a Bournemouth and Poole GP, which will undertake acute assessment and diagnosis, crisis and rapid support, intensive rehabilitation/reablement and treatments for adults and older people.

With the provision of enhanced integrated services delivered in partnership with the Borough of Poole and Bournemouth Borough Council, unnecessary hospital admissions will be prevented and effective rehabilitation services provided to enable early discharge from hospital and reduce the need for premature or unnecessary admission to long term residential care.

Acute care closer to home/intermediate care services can be provided in a person's own home, residential and residential with nursing home, and in a "step up/step down" inpatient community beds which are currently on Jersey Ward, Guernsey Ward, Chalgrove Nursing Home and Broadwaters.

1.2 Evidence Base

The commissioning intentions set out in this specification have been informed by the Transforming Community Services Strategic Commissioning Plan October 2009.

The plan was informed by the following national guidance:

- National service framework (NSF) for older people 2001 / A New Ambition for Old Age 2006
- Our Vision for Primary and Community Care
- A Recipe for Care: Not a Single Ingredient

- Transforming Community Services: Enabling new patterns of provision
- Delivering Care Closer to Home: meeting the challenge (DH, 2008)
- High Quality Care for All: NHS next stage review final report (DH, 2008)
- NHS Next Stage Review: a vision for primary and community care (DH, 2008)
- Our Health, Our Care, Our Say: a new direction for community services (DH, 2006)
- National Quality Requirements in the Delivery of Out of Hours Services (DH, 2006)
- Taking Healthcare to the Patient (DH, 2005)
- NHS Operating Framework 2009/2010
- National Dementia Strategy (DH, 2009)
- Your Health, Your Way – a guide to long term conditions and self care
- NHS choices (2008)
    - Intermediate Care – Halfway Home, Updated Guidance for the NHS and Local Authorities, July 2009
    - Bournemouth and Poole Dementia Strategy
    - Bournemouth and Poole Older Peoples Strategy
    - Bournemouth and Poole Joint Commissioning Strategy for Falls and Bone Health (Draft)
    - Joint Strategic Needs Assessment 2010 - 2015

Acute care closer to home/intermediate care services should be regarded as the provision of integrated services within the community to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living and is delivered in a patients own home or non acute setting. Services will aim to provide care to adults who are registered with a GP in Bournemouth and Poole in a "virtual ward" setting that would meet all of the following criteria:

- Are targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute in-patient care or long-term residential care.
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves opportunity for recovery.
- Have a planned outcome of maximising independence and typically enabling patients/users to resume living at home.
- Is time limited, normally no longer than six weeks and frequently as little as 1 – 2 weeks or less (for reablement this can be longer)
- Involve partnership working, with a single assessment framework

1.3 General Overview

In Bournemouth, and especially Poole, the high and growing number of elderly and very elderly people present a major health need.

Socio-economically, Bournemouth, and particularly Poole have more very affluent people than the England average. However, there are wide disparities between the most and the least well-off, which in Poole is causing a growing health inequality gap.

Population projections in the medium to long term show a continued trend towards an older population, especially the numbers of over 85s. As ill-health increases with age, this is the main challenge for local health and social care services.

Many of the large number of older residents enjoy good health, because of high accumulated wealth and the support this can buy. However, hospitalisation rates are high. For a minority of the elderly, who have fewer assets and lower income, chronic illness rates are high, as are levels of emergency hospital admissions.

Bournemouth and Poole is second only to Dorset in NHS South West for the proportion of older (70+) people admitted for hospital elective care (42%). This rate is rising faster than any other PCT in the region; up from 36% in three years. For non-elective admissions, the rate for older people (75+) is 54%, also second highest to Dorset. However, in this case, the rate has been steady for the last 4 years

There are over 9,000 old people living alone in Bournemouth now, a figure projected to rise to over 10,500 in the next 205 years. By that time, there will be a similar number of elderly living alone in Poole, up from 7,700 today. The current number of people aged 65 and over unable to manage at least one self-care activity on their own is over 22,000, and predicted to rise to over 27,000 by 2025

1.4 Objectives

NHS Bournemouth and Poole commissions services to support patients to receive acute care closer to home/intermediate care. Adults and older people will have access to a redesigned intermediate care service at home or in designated care settings, to promote their independence. By providing enhanced integrated services delivered in partnership with NHS Bournemouth and Poole, Bournemouth Borough Council, the Borough of Poole and other agencies, unnecessary hospital admissions will be prevented and effective rehabilitation services provided to enable early discharge from hospital and reduce the need for premature or unnecessary admission to long-term residential care.
The acute care closer to home/intermediate care service will cover all patients who are registered with an NHS Bournemouth and Poole GP and will be provided in three localities in Bournemouth and four localities in Poole.

The team will be staffed by multi-professional health and social care staff that will include Occupational Therapists, Physiotherapists, Registered Nurses, Advanced Nurse Practitioners, Specialist Nurse Consultant Medical Consultants for older people, Social workers, Multi-skilled Support workers, Mental health nurses, pharmacy technicians, administration support, speech and language therapists and advocacy support from Help and Care.

The acute care closer to home/intermediate care service will provide the following services:

- Admission avoidance services
- Enhanced hospital discharge services (discharge within 24 hours)
- Case finding approach targeting inpatient units and reablement/rehabilitation units
- Strategic admission areas in reach service
- Rapid Access to Consultant Advice
- Direct Access to Consultant Geriatrician for GPs and A&E (0900- 1700, Monday – Friday, excl. bank holidays
- Holistic assessment using the Single Assessment Process
- Specialist Assessments as required
- Goal-orientated community treatment plans
- Multi-professional treatment plans
- Provision of equipment in line with PCT protocol
- Assistance with medicines management
- Social Work Intervention
- Intensive rehabilitation
- Nursing and Home care
- Time limited service up to 6 weeks (longer for reablement)
- Health promotion and self-management programmes
- Rapid access to assessment for patients requiring residential placement
- Step up and step down capacity for in inpatient/community bed facilities. These are currently provided by 50 beds at Alderney Hospital, 16 beds at Broadwaters (available to Bournemouth residents only) and 4 beds at Chalgrove (available to Poole Residents only).

The acute care closer to home/intermediate care pathway will fully support all adults and carers to access the most appropriate rapid medical or social care support when a health or social care crisis occurs.

Managing patient, family and carers expectations will be key to the success of this pathway and it will be essential that the health and social care workforce are committed to the delivery of care through the new pathway and are equipped with the essential skills.

Further work needs to take place on reviewing existing pathways for particular diagnosis or treatments, particularly where treatment/pathways have historically only been provided in the acute sector when the acute episode could have been managed within the community.

1.5 Expected Outcomes including improving prevention

To ensure transformation in the acute care closer to home/intermediate care service, there will be a number of key outcomes that will be achieved. In particular:

- people have a timely response and a comprehensive service when they are in a health or social care crisis;

- people have acute care community service alternatives to hospital and care home admission, therefore reducing unnecessary admission and supporting early hospital discharge;
- people have access to intensive rehabilitation and reablement services close to home to promote their recovery and independence;
- people have personalised care plans;
- people have a wider range of treatments available to them closer to home;
- people have access to integrated health and social care services which are high quality, efficient and sustainable;
- people have active involvement in decisions about their care and support;
- people have choice and control over their care and support so that services are built around the needs of individuals and carers.

2. Scope

2.1 Service Description

The service will provide a locality integrated health and social care acute care closer to home/intermediate care service which will provide acute rapid assessment and diagnosis, crisis support, intensive rehabilitation/ reablement and treatments such as intravenous and hydration therapies.

The services are:

a) integrated community teams:

- provided in four localities in Poole and three localities in Bournemouth;
- will consist of nurses, social workers, generic support workers, doctors and therapists, working with the long term conditions locality teams, general practitioners, generalist palliative care teams, domiciliary carers and voluntary sector providers in each locality;
- will provide services to people aged 18 years and over;
- will be available from 0700 to 2200 seven days a week, 365 days per year across Bournemouth and Poole;
- will be accessible to individual patients for a maximum of six weeks. (The reablement aspect of the care package may exceed this period depending on the patients need);
- will accept referrals 7 days per week
- will be accessed through a single point of access;
- will work towards single line management of the staff employed by Bournemouth and Poole community services and the Local Authorities;
- will have identified key workers for each general practice.

b) intermediate care units:

- will be provided 48 beds at Guernsey and Jersey Wards, Alderney Hospital, 16 beds at Broadwaters (available to Bournemouth residents only) and 4 beds at Chalgrove Care Nursing Home (available to Poole Residents only)
- will provide services in line with each establishments CQC registration;
- operate 24 hours a day, 365 days per year;
- will accept admissions 7 days per week, provided that there is sufficient medical cover available to maintain a safe patient transfer (currently the service is not funded for 7 days per week medical support);

- will support discharges 7 days per week

Broadwaters

Broadwaters unit is a Bournemouth Borough Council 29 bedded unit registered residential home of which there are 16 intermediate care beds which are jointly commissioned to work in an integrated coordinated way to respond to people's health and social care needs providing:

Social care component:

- reablement for people with complex social care needs who require promotion of independence and development of life skills, that cannot be managed and delivered adequately and safely in their own home, due to the level of complexity and intensity of their needs;

Healthcare component:

- rehabilitation for patients with complex healthcare and/or intensive rehabilitation needs that cannot be managed and delivered adequately and safely in their own home, and do not require the specialist medical assessment and interventions provided by an admission to an acute hospital;
- care for patients referred from either the community (traditionally known as 'step-up' care) and from acute or specialist hospitals (traditionally known as 'step-down' care), aiming for a ratio of 50% step up and 50% step down basis.

Chalgrove Care Nursing Home Beds

The Borough of Poole commissions four "step up step down" beds at the privately registered nursing home The Chalgrove Care Nursing Home. Access to these beds is managed by the acute care closer to home/intermediate care service.

Alderney Community Hospital: Jersey and Guernsey Wards

Alderney Community Hospital is a 48 bedded in patient nursing and medical care facility for adults who need intensive rehabilitation combined with medical or nursing care needs where these needs cannot safely be met in a person's own home by the acute care closer to home service or the long term conditions team.

Key services for the Alderney wards include:

- Nurse Consultant
- Consultant ward rounds (once a week per ward)
- Doctor – provides 'in hours' medical cover to all patients.
- Out of hours medical cover is currently provided by the 'Dorset and Somerset Out of Hours' service for patients requiring medical attention from 18:00 – 08:00 and weekends.
- Social services
- IMCA support – can be accessed to provide advocacy support for patients without mental capacity.
- Speech therapist service – provided on a sessional basis
- Dietician - provided on an ad hoc basis
- Help and Care Advocacy
- Specialist support teams
- Services provided by SLA by DHCFT (contract currently managed by NHS B&P)

This list is not exhaustive and all necessary services will be contracted by the provider.

The services will provide:

- comprehensive therapy, nursing, medical and social care, advanced assessment, review and personalised care planning using a single assessment process to ensure that information from assessment and related activities are shared and coordinated among and across professionals, (with due regard to data protection), and to reduce duplication;

- engagement of patients/service users and their carers in the formulation of care plans;
- comprehensive locality based crisis support and treatment, and intensive rehabilitation/reablement for people whose needs exceed that which can be provided by the locality long term conditions teams alone, due to the nature of the intensity and complexity of their needs, to reduce unnecessary reliance on care home and hospital services;
- effective engagement and in reach into inpatient units to reduce length of hospital or care home stay, by engaging in discharge planning and facilitating early safe discharge home or to intermediate care beds, for people requiring intensive rehabilitation/reablement and treatment beyond that which can be provided by the locality long term conditions teams alone, due to the nature of the intensity and complexity of their needs;
- services in a range of settings such as nursing and residential care homes, social settings, patients home, clinics and intermediate care units;
- services which have consistent and comparable eligibility criteria across the conurbation of Bournemouth and Poole;
- community based services will undertake an assessment within two hours of referral for urgent referrals (48 hours for therapy under current funding arrangements) and within 48hrs for non urgent referrals (14 days for therapy service under current funding arrangements);
- close working with GPs, out of hours providers, emergency departments, ambulance trusts to ensure the effective management of patients across the care pathway;
- assessment and management of individuals for the use of assistive technology to manage their health and social care needs and who will either individually or with the help of carers, use assistive technology safely and with proper governance; (This contract does not include the service procuring the assistive technology as this is funded by the local authority.)
- diagnostic services and equipment such as Doppler, syringe drivers, 24 hour blood pressure monitors;
- effective and timely use of equipment services;
- medicine review and management plan for each individual to ensure optimisation of treatment plan and effective engagement with pharmacy services;
- multidisciplinary /multi agency case conference / reviews as appropriate;
- advocacy for patients and / or carers as appropriate through direct provision or referral.

NHS Bournemouth and Poole plans to decommission and re-commission clinical pathways based on national best practice and evidence. Areas that will be considered for further development are the management of:

- urinary tract infections;
- falls;
- IV fluids;
- IV diuretics;
- deep vein thrombosis;
- IV antibiotics;
- blood transfusions;
- cellulitis;
- iron infusions for chronic kidney disease.

This list is not exhaustive.

BPCHS will work in year to achieving equity of service hours, skill mix, and integration of the therapy teams, a coherent and consistent service across Bournemouth and Poole, including capacity to reflect locality needs,

through service redesign.

The integrated community teams will operate between 07.00 – 22.00 seven days per week.

2.2 Accessibility/acceptability

The community based services will be provided in four localities in Poole and three localities in Bournemouth to all people age 18 years and over and registered with Bournemouth and Poole GP and will be accessed through the single point of contact

2.3 Whole System Relationships
GP Practices
Royal Bournemouth and Christchurch Hospital NHS Foundation Trust
Poole Hospital NHS Foundation Trust
Bournemouth Social Services, Poole Social Services and Dorset Social Services
Bournemouth and Poole GP's
Third sector and community organisations

2.4 Interdependencies

- Broadwaters beds provided by Bournemouth Social Services
- Chalgrove Care Nursing Home beds provided by Poole Social Services
- Nottingham Rehabilitation Services (NRS) provides equipment for patients to promote independence in their own homes.
- Alderney site and support site services provided by SLA by DHCFT (contract currently managed by NHS B&P)
- Social services – for onward transition from acute services into long term care.

2.5 Relevant networks and screening programmes

The following networks and screening programme relating to the service have been identified how ever this list is not exclusive and other networks and screening programmes may also be identified over time:

- Falls risk screening in line with NICE Clinical Guideline 21;
- Home Safety Checks involving Dorset Police and Dorset Fire and Rescue Service;
- The National Institute for Clinical Excellence;
- Infection control forums;
- National Service Framework for Older People;
- Safeguarding Adults;
- National Patient Safety Agency;
- Local authority governance and statutory requirements
- Delayed transfers of Care
- Institute for Innovation and Improvement the Productive Ward and Productive Community Hospital
- Elimination of mixed sex hospital accommodation

3. Service Delivery

3.1 Service model

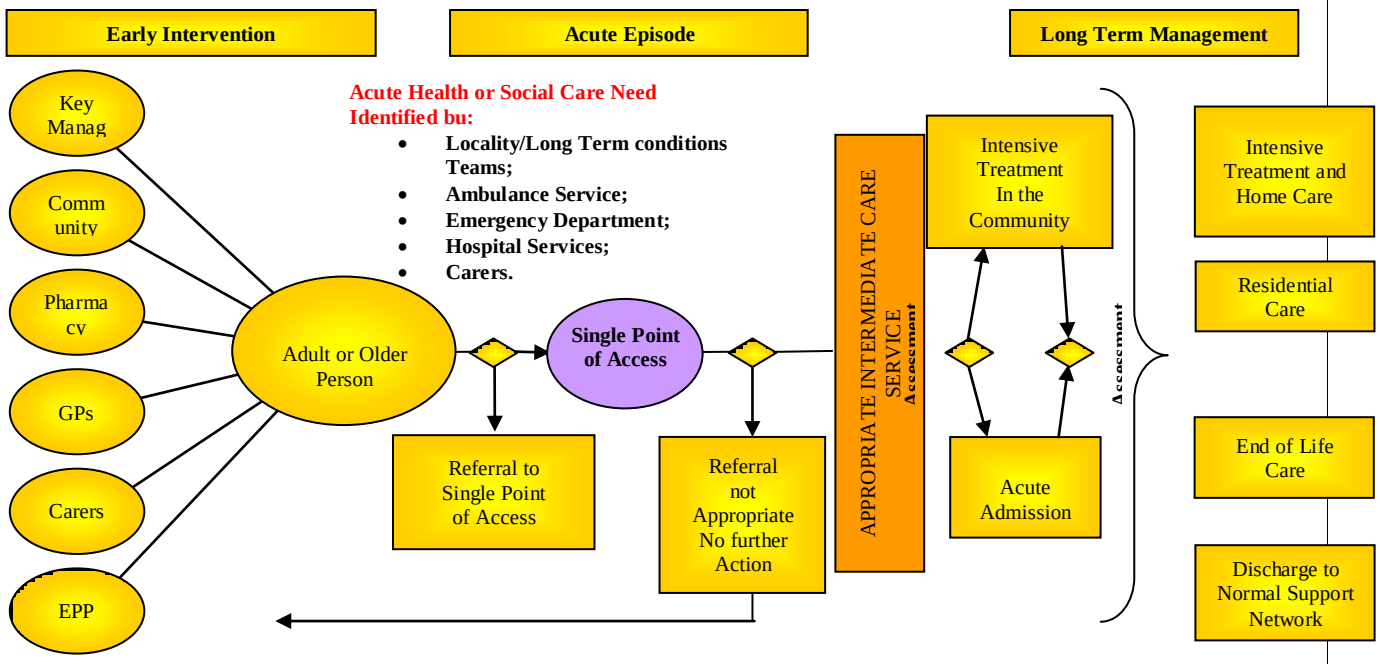
The commissioning plans for NHS Bournemouth and Poole are built around the concept of services that are centrally co-ordinated through the single point of access.

The acute care closer to home pathway will fully support all adults and carers to access the most appropriate rapid medical or social care support when a health or social care crisis occurs.

Managing patient, family and carers expectations will be key to the success of this pathway and it will be essential that the health and social care workforce are committed to the delivery of care through the new pathway and are equipped with the essential skills.

The provider will engage in further work to review disease specific pathways existing pathways for particular disease specific pathways diagnosis or treatments, particularly where treatment/pathways have historically only been provided in the acute sector when the acute episode could have been managed within the community.

3.2 Acute Care Closer to Home Care Pathway



4.1 Geographic coverage/boundaries

Patients who are registered with an NHS Bournemouth and Poole GP.

4.2 Location(s) of Service Delivery

Community Services will be delivered within the seven localities of Bournemouth and Poole and in reaching into the acute sites at Royal Bournemouth and Christchurch Hospital NHS Foundation Trust and Poole Hospital NHS Foundation Trust and other community rehabilitation and reablement units.

Inpatient facilities will be delivered at Guernsey and Jersey Wards, Alderney Hospital, Broadwaters Care Home and Chalgrove Care Nursing Home.

4.3 Days/Hours of operation

Community services will be available from 0700 to 2200 seven days a week, 365 days per year across Poole and Bournemouth.

Inpatient services operate 24 hours a day, 365 days per year.

4.4 Referral criteria & sources

Community Services will provide services to people aged 18 years and over and will accept referrals 7 days per week from a range of health and social care professionals via the single point of access.

Inpatient services will accept admissions 7 days per week, provided that there is sufficient medical cover available to maintain a safe patient transfer (currently the service is not funded for 7 days per week medical support).

In addition to receiving referrals staff will proactively case find patients appropriate for the service using the daily case finding list, via GPs and responding to daily emergency admissions.

The following information will be essential when making a referral:

- Patient name
- Hospital/Social Services/NHS number if known
- Date of birth
- Address
- Telephone number
- GP
- Diagnosis/relevant medical history
- Nature of current problem/reason for referral
- Urgency of referral
- Current medication
- Current social situation
- Details of next of kin/carer
- Name of referrer and contact details
- How to gain access to the property
- Any risks to visiting for the health or social care professional

4.5 Referral route

Referrals will be via the Single Point of Access.

Following referral, a professional from within the team locality will carry out an assessment. This initial assessment will include Single Assessment, risk assessment and any additional Specialist Assessments as required.

Following assessment, the team will set treatment plans and goals. If input from other Specialist Services is required ongoing referrals will be made.

4.6 Exclusion criteria

For Alderney wards:

- People aged under 18
- Patients who are not registered with a NHS Bournemouth and Poole GP.
- Patients who have no physical health need, only a mental health need.
- Terminal care for those patients on the Liverpool care pathway prior to discharge from the acute hospital.
- The patient has no physical need, only a social care or housing related need.
- Patients who have no physical need, but who are awaiting a decision regarding continuing health care.
- Where a patient is clinically unstable or requires cardiac monitoring.
- Patients who are receiving care in another local rehabilitation facility.

4.7 Response time & detail and prioritisation

Rapid response / urgent referrals within 2 hour from time of referral (Community Therapy are currently contracted to respond to urgent referrals within 48 hours).

Supported Discharge within 48 hours from date of referral.

5. Discharge Criteria and Planning

Patients that have returned to their pre-morbid state or who have maximised there potential to improve within a few weeks will be discharged from this service with appropriate signposting and referral to long term support services.

A discharge letter as set out in the contract will be sent to the GP with copies to community nursing. A copy is also sent to the social worker if involved.

The patient's views will be central to the discharge planning process.

The patient will be discharged once they have:

- Reached a point in their recovery where improvement can be undertaken independently in their own home;
- Decided to discontinue receiving the service;
- Reached a point where a different service or agency is best suited to meet their needs;
- Met agreed goals.

Effective use of outcome measures will be a key part of the discharge process.

The team will aim to discharge the patient to an acceptable risk assessed environment as soon as possible. Where there is a perceived ongoing risk, they will undertake risk assessments and involve the patient's carers and primary health care team as appropriate.

Where a patient's clinical condition cannot be supported at home but does not requires acute hospitalisation or residential placement consideration may be given to a "step up, step down" use of a community bed.

6. Prevention, Self-Care and Patient and Carer Information

Self-care is the main aim of acute care closer to home. Patients are encouraged where appropriate to manage their care needs, patient empowerment is at the forefront of the service coupled with equality and dignity

Carers should be actively involved in the assessment for care provision and receive appropriate information.

Carers assessments should be undertaken by the acute care closer to home team and carer information leaflets should be made available.

It is anticipated that the acute care closer to home team will produce its own literature on the services that can be provided and this will reflect the joint working with the Borough of Poole and Bournemouth Borough Council.

Description of Scheme	*Milestones*	*Expected Benefit*	*Timescales*	*Frequer Monitori*
Transforming Community Services Strategic Commissioning Plan October 2009 – implementation and redesign of intermediate care services		To meet objectives of the service specification	2012/13	Monthly
Strengthen partnership working across health and social care and develop partnerships with organisations such as the ambulance trust, acute trusts, GP practices , the voluntary and independent sectors so that care and treatment can be aligned along a care pathway and coordinated around the needs of the	As agreed within BPCHS project plan	To meet objectives of the service specification	2012/13	Monthly

service users					
Development of an equitable service across the locality of Bournemouth and Poole – this will include hours of operation, access to in patient beds, A&E in reach services and falls services, as detailed in this specification.	As agreed within BPCHS project plan	To meet objectives of the service specification	2012/13	Monthly	
Development of clinical pathways with commissioners to provide particular diagnosis or treatments, particularly where treatment/pathways have historically only been provided in the acute sector when the acute episode could have been managed within the community, as detailed in this specification.		To meet objectives of the service specification	2012/13		
Continue development of a case finding approach within the acute hospitals to ensure that patients are discharged as early as possible, ensuring that the process and care is coordinated need to confirm this please?		To meet objectives of the service specification	2012/13	Monthly	
Work with commissioners to analyse the health needs of the population: identifying those who may be disadvantaged to target need		To meet objectives of the service specification	2012/13		
Work with commissioners to agree outcome data for collection to demonstrate effective intervention	Monthly activity and outcome reports	Improved understanding of the benefit of the service	Monthly activity and outcome reports and Quartery Governance Reports	Monthly	
Develop systems and processes, which encourage constant patient, service user and carer feedback	Monthly activity and outcome reports	To meet objectives of the service specification	Monthly activity and outcome reports and Quarterly Governance Reports	Monthly	
Develop systems and processes, which encourage constant patient, service user and carer feedback	Monthly activity and outcome reports	To meet objectives of the service specification	Monthly activity and outcome reports and Quarterly Governance Reports	Monthly	
Single line management for the acute care closer to home/intermediate care service with Bournemouth Borough Council and the Borough of Poole		To meet objectives of the service specification	By end of Quarter 4 2011/12	Monthly	

8. Baseline Performance Targets – Quality, Performance & Productivity

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Additional Measures for Block Contracts:-				
Staff turnover rates				

Sickness levels				
Agency and bank spend				
Contacts per FTE				

9. Activity

9.1 Activity	*Method of measurement*	*Baseline Target*	*Threshold*	*Frequency of Monitoring*

9.2 Activity Plan

Monthly activity reports with a minimum data set of total and new contacts.

9.3 Capacity Review

10. Currency and Prices

10.1 Currency and Price

Basis of Contract	Currency	Price	Thresholds	Expected Annual Contract Value
Block/cost &volume/cost per case/Other_____*		**£**		**£**
Total		**£**		**£**

**delete as appropriate*

10.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Total	Associate Total	Associate Total	Total Annual Expected Cost
£	**£**	**£**	**£**	**£**	**£**