SCHEDULE 2 – THE SERVICES

A. Service Specifications (Full Length Contract)

Service Specification No.	11J/0239
Service	Community Beds - DHC
Commissioner Lead	Director of Primary and Community Services
Provider Lead	Director of Operations
Period	1st September 2018 – 31st March 2021
Date of Review	March 2021

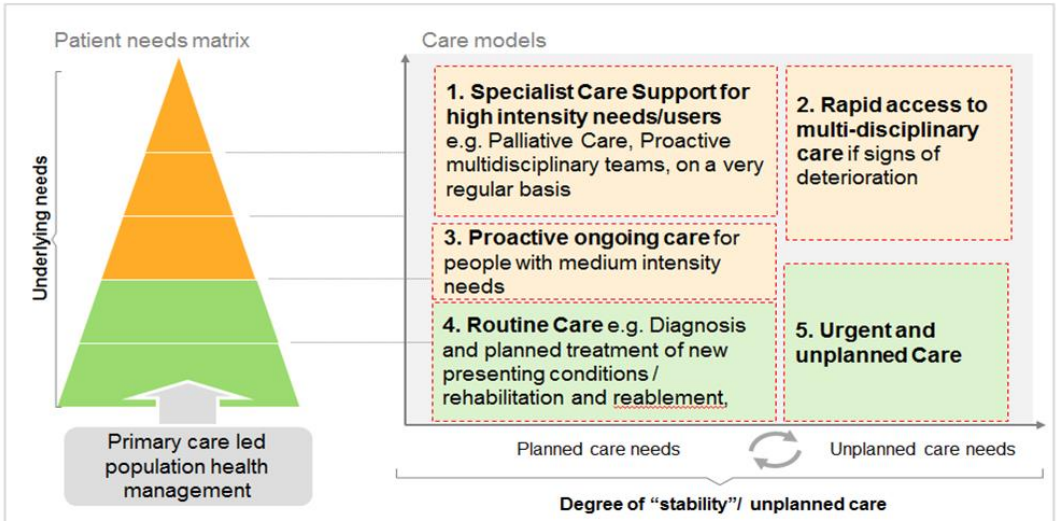
1. Population Needs

1.1 National/local context and evidence base

The case for change in community and primary care services is detailed in the Integrated Community and Primary Care Services (ICPS) Outline Business Case. Building on these ambitions, it is important to note that nursing care and rehabilitation will primarily be delivered within a person's home wherever possible and that referral to a short term care home/community hub will only be necessary for a defined cohort of people.

The purpose of commissioning short term beds in care homes and community hubs is to provide step up and step down rehabilitation, reablement and end of life care and support within a defined timeline for patients who are unable to receive this service at home or where admittance to an acute hospital ward is not required.

The specification of this service is designed to complement the services we already have supporting our population who are high intensity users. The Key Features and Functions of Community Beds have been agreed by the System and supports the model of care agreed.



2. Outcomes

2.1 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**	✓

2.2 Local defined outcomes

- Average occupancy rate of 85%,
- Average length of stay of 22 days (calculated 369 beds, now moved to an average length of stay of 24 days and additional 67 beds, average length of stay 3 days.)
- Approximately a third of beds used for step-up care from community teams.

3. Scope

3.1 Aims and objectives of service

Community beds for short term rehabilitation, reablement or end of life care will be available across the County within community hubs with beds or in locality care homes where the service is commissioned.

Community short term care home beds for Rehabilitation, Reablement and end of life care (step up, step down or transition) will be available in areas of the county where there is a community hub without beds but it is recognised that there is a requirement for residential beds with suitably trained and skilled staff to accommodate a small number of patients who require a period of care and support related to their rehabilitation or reablement goals or at the end of life. The provision of these beds will form part of a range of options to support people's different levels of need whilst providing care and support close to home.

The beds will be provided to support the philosophy of Reablement, Rehabilitation which promotes the independence of the patient to lead the life they wish thereby reducing their dependency on support packages through the use of a reablement approach, ensuring that the customer and their families, relatives or carers:

- Are fully aware of the purpose of their short term placement, has agreed the outcomes and are committed to returning home;
- Are supported to return home following their short stay in a care home bed;
- Will have the opportunity to engage in conversation with staff and other residents;
- Will be recognised as a contributor to the delivery of their own joint Care and Support Plan;
- Will identify their outcomes or by Best Interest Decision Making should the individual be unable to identify their chosen outcomes themselves;
- Are recognised that they are able (with capacity) to make their own choices and decisions regarding risk with the support and advice of others where required.

The World Health Organisation states that rehabilitation intervention should be aimed at

achieving the following broad objectives:

- Preventing the loss of function
- Slowing the rate of loss of function
- Improving or restoring function
- Compensating for lost function
- Maintaining current function

These principles apply in a holistic way to encompass both physical and mental health *NHS England Commissioning Guidance for Rehabilitation 2016.* In addition, the provision of rehabilitation and reablement beds should be;

- Targeted at people who would otherwise face prolonged hospital stay or inappropriate admissions to acute inpatient care or long term residential care;
- Provided on the basis of a comprehensive assessment, resulting in a structured individual care plan;
- Have a planned outcome of maximising independence and typically enabling patients to resume living at home;
- Are time-limited, the expected time frame being within 2 weeks and normally no longer than 6 weeks ;
- Involve cross-professional/ agency working

Intermediate Care: Halfway Home (Department of Health, 2009)

3.2 Service description/care pathway

Community beds for rehabilitation, reablement and end of life care will be primarily used to support frail and older people with rehabilitation or end of life care needs that cannot be managed within their own home environment. See Key Features and Functions of Community Beds for greater detail.

Community Hubs vary in size, the table below indicates the outcome of the clinical services review (CSR).

Community Hub	**Number of Beds**	**Anticipated no of beds used for step-up care**
Wimborne	24	8
Wareham	0	0
Swanage	15	5
Blandford	24	8
Shaftesbury	12	4
Sherborne	30	10
Bridport	24	8
Weymouth	36	12
Alderney	48 (to be relocated to Poole Hospital site)	16
Wareham Care Home Beds	TBA	
Weymouth Care Home Beds	TBA	

3.3 Population Covered

Adult patients, over 18 years, registered with Dorset GP practices.

3.4 Any acceptance and exclusion criteria.

The service is predominately for local people but out of area admissions/transfers are accepted to relieve pressures within the healthcare system, but regular and increasing use by other CCGs will be flagged to the CCG.

3.5 Interdependence with other services/providers

Enhanced frailty specification
Key Features and Functions of the ICPCS Model of Care
Current service providers for acute care.
Social Care
System working across all partners – in line with the East and West Integrated Healthcare Partnership
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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

Key Features and Functions of Community Beds

Key Features and Functions of the Model of Care

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

KPI	Definition	Reporting Period	Tracked & Reported by	Minimum Standard
Approximately a third of beds are used for step-up care	Direct admissions from community teams to these beds	Monthly	Provider	30%
Patients are accepted 7 days a week	Admissions are not affected by the day of the week.	Monthly	Provider	100%
Average Occupancy Rate	As nationally defined	Monthly	Provider	85%
Average Length of Stay	Length of stay	Monthly	Provider	22 days (interim target 24 days)

Patients are transferred with a home first approach, with access to a bed if clinically appropriate	Patient flow is understood and a home first approach is embedded across the system	Monthly	Provider	100%
Patients arrive before 6pm	To understand the proportion of patients arriving before 18:00 and identify reasons that have prevented this	Monthly	Provider	80%
A comprehensive assessment is made within 24 hours	Patients changing needs are identified and EDD set	6 Monthly at contract review		100%
For sub contracted care home beds - the care home will be required to meet the following standards which will be monitored by Dorset Healthcare.				
Care home staff training undertaken on nursing skills, moving and handling, rehabilitation and end of life care	That care home staff have attended training sessions as provided by the In-reach Community team	6 Monthly at contract review		80%
Rooms within a care home are identified as Rehabilitation and Reablement, EOL care within a defined area	That the Rehabilitation and Reablement rooms are clearly identified as such and situated in one area EOL care	6 monthly – at contract review	Provider	95%
Number of issues experienced with admissions into beds e.g. time of arrival, delayed discharge	To identify and improve areas of issue.	6-monthly	Provider	

All patients have a named care manager that the patient and family are aware of	Patients and their family/carers have a named point of contact	Monthly	Provider	100%
All patients have a DACP or end of life care plan started or continued	All patients receive an initial review at the beginning of their episode	Monthly	Provider	100%

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

See section 3.2 above

7. Individual Service User Placement