NHS Dorset Clinical Commissioning Group

Dorset County Council

DORSET COMMISSIONING PARTNERSHIP

DORSET CARE

SERVICE SPECIFICATION:

RAPID RESPONSE

Segment 1

Lot 4

Contents

Introduction

1.1 This specification should be read in conjunction with the Commissioning Intentions document, the Dorset Care Framework Overarching Service Specification (Document 1), Service Specification: Care and Support at Home (Segment 1, Lot 1), and additional information provided within the appendices. These documents will form part of the final contract for successful bidders.

1.2 This document specifies the requirements which apply to the provision of a Rapid Response Service.

2. Aims and outcomes of the service

2.1 The Rapid Response service will provide responsive and flexible Care and Support at Home services which assist in the reduction in delayed discharges from acute and community hospital (early home from hospital discharge, hospital throughput), move on from the Re-ablement Service or pre Re-ablement service freeing up capacity, and Frail Older Person Assessment Unit (hospital prevention).

2.2 The outcome of this service is to reduce the incidence of delayed discharge from acute and community hospitals.

3. Description of the service

3.1 Services under Rapid Response will be available 24 hours a day, seven days a week, every day of the year. The service should be available within two hours of referral.

3.2 The Service will provide Care and Support for a maximum of 72 hours per Service User within a consecutive three day period. Following the 72 hour period, Care and Support will either no longer be required or alternatively, longer term care will be arranged. This may include the Provider transferring the Service User to their existing long term Care and Support at Home service.

3.3 The service will provide short term, crisis Care and Support at Home for adults leaving hospital, who are awaiting a longer term package of care. The aim will be to move these Service Users on to longer term services as soon as possible, either to the Provider's own service or to an alternative provision.

3.4 The service will provide home from hospital Care and Support, liaising with the hospital discharge team, the transportation team and/or responsible Commissioning Partners' Brokerage team, to agree the individual rapid response

package.

3.5 The service will also respond to referrals from the Frail Older Persons Assessment Unit, providing Care and Support in order to prevent admission to hospital.

3.6 The Provider will receive the Service User's Care and Support plan containing sufficient detail for the Provider to make a first visit and assessment either in the hospital or shortly after the Service User arrives home from hospital, whichever can be done more quickly, with any medications and 72 hour discharge instructions.

3.7 In order for the Provider to be able to maximise their ability to respond to requests for Care and Support, referrals will not be time specific, unless in exceptional circumstances when specific timed visits are required to ensure the safety of the Service User.

4. Service access and commissioning

4.1 Referrals to the service must be made through the responsible Commissioning Partners' Brokerage Team, Operational Team or Out of Hours Service.

4.2 The Commissioning Partners accepts that to enable the service to perform to maximum efficiency, the Provider needs to receive timely and accurate Service User details to ensure service delivery.

5. Review and discharge

5.1 The Provider will email the responsible Commissioning Partners' Brokerage team or Operational Team with a weekly update of service availability.

5.2 The Provider will record and submit weekly:

- Name of Service User
- Type of Care and Support provided
- Start date of Care and Support
- End date of Care and Support
- Date of transfer of Care and Support and where to, if known

- Total hours of Care and Support delivered
- Total visits weekly
- Total travel and non-contact time weekly
- Total miles travelled weekly
- Total packages not accepted and why

5.3 All information, records of visits and monitoring sheets will be provided for information with the assessment process.

5.4 The responsible Commissioning Partners' Brokerage Team will maintain an overview of the referrals and their geographical locations in order to ensure that the Provider is given every opportunity to mobilise the service as efficiently as possible.

6. Quality monitoring

6.1 Services and/or interventions will be monitored in line with Appendix 1: Care and Support at Home Quality Monitoring Standards.

7. Performance monitoring

7.1 The performance monitoring measures are set out below and should be submitted on quarterly basis to the responsible Commissioning Partner.

KPI Reference	Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4
R1	Number of beds 'unblocked' from acute and community hospitals in each week and reduction of days delayed				
R2	Total number of admissions prevented in each week				
R3	Number of hospital admissions prevented				
R4	Type of requests refused				
R5	Number of contact hours per week (to assess ratio of contact to travel/non-contact time)				
R6	Number of non-contact hours and travel time each week				
R7	Number of miles travelled each week				
R8	Number of visits in a week				
R9	Average length of time to transfer to long term care				
R10	Number of packages transferred into long term care internally				
R11	Number of packages handed back to brokerage to broker long term packages				
R12	Number of requests refused and reason for refusal				

7.2 This supports the Commissioning Partners overarching performance monitoring framework. See Appendix 3.

8. Call Off Process

8.1 The Commissioning partners intend to use supplementary quality questions when the lot is opened and set maximum prices as part of a mini-competition process for this lot.