

SECTION 1 – SERVICES

Section 1 Part 1: Specification

Care Pathway/Service	Enhanced Intermediate Care Services - Dorset
Commissioner Lead	Director of Joint Commissioning and Partnerships NHS Dorset/NHS Bournemouth and Poole
Provider Lead	
Period	1 April 2012 to 31 March 2013
Date of Review	
Applicability of Module E (Acute Services Requirements)	

Key Service Outcomes

Intermediate care services form an important part of the care continuum for people whose care needs exceed those offered by 'routine' primary health care and social support, yet whose management does not require admission to an acute hospital or to a long term institutional care setting. The strategic aims of intermediate care were concisely stated "To promote faster recovery from illness and prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living" (NSF 2001).

The key service aims are to ensure the provision of high quality, responsive delivery of intermediate community services with effective use of resources in a timely and responsive manner to meet the needs of the Dorset population.

This will build on evidence based best practice and support care closer to home. Care will be delivered by competent health and social care teams, with an appropriate skill mix, working seamlessly in the delivery of care and engaging with patients to promote self management and self care, offering maximum choice and control whilst effectively managing risk which optimises an individual's outcomes and well being at every opportunity.

1. Purpose

1.1 Aims and objectives

To provide a locality integrated multi-professional intermediate care service for all adults over the age of 18 who are registered with a Dorset GP, which will undertake assessment and diagnosis, crisis and rapid support, intensive rehabilitation/reablement and treatments for adults and older people.

With the provision of enhanced integrated services moving toward service delivered in partnership with Dorset County 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.

Integrated, intermediate care services can be provided in a person's own home, in care

homes (including where appropriate care homes registered to provide nursing care), and in “step up/step down” community bed based services.

1.2 National/local context and evidence base

The commissioning intentions set out in this specification have been informed by the NHS Dorset Strategic Plan for a Healthier Dorset 2010- 2014 which set out the key priorities for health care in Dorset. The primary objectives are to help people to stay healthy, to remain at home and/or return home following a bed based admission and to provide care as close to home as possible.

As part of Dorset County Council’s Transforming Adult Social Care programme the principle of early intervention suggests that supporting the individual with modest needs, even those who are ineligible for services, may prevent the need for more expensive care later in life.

A number of key outcomes are identified for ‘transformed’ social care which link to Community Services, these are to:

- Live independently
- Stay healthy/recover quickly from illness
- Have the best quality of life

Mental health and dementia care are core components of service delivery and this is further supported in the recently published “No health without mental health: A cross government mental health services strategy for people of all ages” (DH Feb 2011). The document sets down six key objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Commissioned integrated services will be supported by the Connecting Health and Social Care programme for Dorset which moves from alignment to integration and supports the shift from hospital to locality and community based services. This type of care delivery requires fully integrated response across health and social care, housing, employment, benefits and voluntary sectors as many patients along with their physical health needs will have social, psychological, economic and environmental factors that cause additional complexities to their care needs.

Commissioning intentions have been 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)
- “No health without mental health: A cross government mental health outcomes strategy for people of all ages” (DH Feb 2011)
- 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
- Joint Strategic Needs Assessment 2010 – 2015
- NHS Improvement – Stroke Psychological Care 2011
- QIPP Long Term Conditions Workstream, Southwest Operational Phase 2011

Services 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.
- Provided on the basis of a comprehensive, holistic, person centred, single assessment, physical, psychological and social, 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 remain/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 and professional confidence in hand over from one service to another

2. Scope

2.1 Service Description

Services will be provided by locality based intermediate care teams comprising nurses, (both general and with access to mental health nurses) social workers, generic support workers, reablement workers, therapists (including speech and language, physiotherapy and occupational therapy) with support for medicines management.

Core services to be provided include:

A locality based, integrated multi-professional intermediate care service for all adults over the age of 18 which will undertake assessment and diagnosis, crisis and rapid support, intensive rehabilitation/reablement and treatments. This will include a clear pathway to access, seek expert advice and refer onto community based mental health services. The service will work toward the integration of health and social care services.

Enhanced support services will be located within a team and will work across identified localities to provide services such as heart failure nurses, tissue viability nurses, continence specialist services, specialist stroke and neurological allied health professionals (including MS and Parkinson’s disease specialist nurses) and will provide advice and support on care and treatment for patients, carers and staff.

Stroke rehabilitation – timely stroke/neurological specialist multidisciplinary rehabilitation and support which is consistent with that received in secondary care; physiotherapy, occupational therapy and speech and language therapy in the community to individuals with mild to moderate symptoms following a stroke. This will include psychological assessment including the PHQ 9 and GAD 7 with psychological interventions provided up to Step 2 where required.

Step up step down bed based services with access to beds via the intermediate care teams

Phase one of the step up/step down services will commence with direct admission to Bridport and Westhaven Hospital from 1st February 2012 Blandford and Purbeck from 1st July 2012 and will provide:

- 6 direct admission beds on Radipole ward (Westhaven Community hospital) 6 direct admission beds on Ryeberry ward (Bridport Community hospital) 6 direct admission beds on Tarrant ward (Blandford community hospital) 6 direct admission beds within the Purbeck locality
- A high standard of inpatient medical, nursing and therapeutic treatment and care which cannot reasonably be provided to patients in their own home and for whom admissions to acute hospitals are not indicated including;
- A planned outcome of maximising independence, based on a structured person centred holistic care plan (physical, psychological and social) that involves active therapy or opportunity for recovery enabling patients to resume living at home and avoid long term residential placements
- A time limited service from 1 day to a maximum of 2 weeks.

2.2 Any exclusion criteria

Patients registered with Lyme Regis Medical Centre are excluded from this service specification as these services are commissioned through alternative commissioning arrangements.

2.3 Geographic coverage/boundaries

The service must be provided to all those individuals who are registered (Including temporary registration) with an NHS Dorset GP. Where the provision of the service to individuals who live outside a locality boundary is required, additional arrangements must be made for the individual to receive the service which could include working with neighbouring Community Service Teams.

The delivery of this service will ensure an equitable service operates to all those registered with a Dorset GP and that individuals are not disadvantaged because of their geographical location or because they are hard to reach, for example groups who suffer from social exclusion, including homeless people, travellers, asylum seekers, refugees, people with disabilities, those living in deprivation and prisoners. Members of these groups tend to suffer high levels of morbidity and premature death.

The long term vision will be for seven intermediate care teams, one based in each locality; however some localities may have outreach spokes from the locality hub in order to cover the large rural landscape of Dorset.

Dorset are currently working with integrated teams and combining planned care services with the intermediate care services to deliver a seamless service that meets the needs of the locality model and delivers an integrated model that is efficient and cost effective.

2.4 Whole system relationships

Multi-disciplinary and multi-agency teams must work in a holistic integrated care approach with a common purpose, learning and developing alongside each other, understanding and respecting each other's contributions and co-ordinating their services for the maximum benefit of individuals, carers, families and communities.

2.5 Interdependencies and other services

The following agencies directly and indirectly influence the work of community teams and therefore it is essential to ensure that systems are in place to provide good communication and a smooth transition for patients and carers between and across these services (this list is not exhaustive)

- Primary care teams
- Acute services
- Mental health services
- Health Visitors/School nurses
- Social services
- Carers
- Hospices
- Transition services
- Learning Disabilities
- Ambulance service
- Equipment services
- Community Pharmacies
- Voluntary sector/third sector
- Independent providers
- Offender health services
- Neighbouring local authorities and healthcare providers

A Menu of services that are funded under the reablement project board and may be accessed by the intermediate care teams :

Short term crisis care packages (responsibility of Dorset County Council):

- Short term care packages which can include 24 hour live in care and which will be in place for no more than 72 hours
- These will be used to support people in their own home for a short period of time to avoid an admission or to facilitate early discharge
- The Dorset County Council Locality Manager and the Dorset Community Health Services Locality Manager will authorise each package and will be responsible for ensuring the pack is withdrawn as soon as possible and within the 72 hour period
- The Intermediate Care Service will work with the individual whilst this care is in place.

Life style monitoring systems (Responsibility of Dorset County Council):

- Remote movement monitoring systems which can be placed in an individual's home to allow people to be assessed in their own home and act as an aid to inform their long term assessment
- The placement of the units is only a temporary but there is no time limit

Individual funding for Delayed Transfers of Care. (Responsibility of NHS Dorset Commissioners)

Patients identified by commissioners at weekly discharge meetings with the acute providers and funding provided for:

- Interim packages of care to patients from acute and community hospitals who are identified as delayed transfers of care and whose continued stay in a bed based service while discharge is facilitated is inappropriate
- Alternative care pathways where appropriate until the recommended pathway is accessible
- Night care/24 hour care provision may be offered for up to a maximum of 2 weeks to allow for the individual to settle and assessment to be undertaken in the most appropriate setting
- Care may be provided for a maximum of 2 weeks and would be brokered through

DCC brokerage officers. This excludes those individuals awarded Continuing healthcare funding

Low level support services for people with dementia Provided by third sector including: Memory Advisory Service (Responsibility of Dorset County Council)

- Provides a local point of contact for people with memory impairment or dementia and their families at all stages of their journey, pre and post diagnosis.
- The memory advisory service will provide support and aid training and educate for people with memory impairment or dementia, their families and care staff in localities
- The Memory Advisory Service will signpost individuals to further support services such as Melodies for Memory and Memory Cafes.

Where enhanced services, are provided, they must support the work of the Community services/teams and avoid becoming the focus for care, at the risk of distorting behaviour in a way that is not best for patients and leads to the neglect of general community service delivery.

2.7 Training/ education/ research activities

The service model will comply with best practice and it is the responsibility of the provider to ensure implementation of any best practice evidence based guidance. Services will be assessed against National Clinical Strategies, National Institute for Health & Clinical Excellence (NICE) Guidance, and agreed best practice. Where there is a resource implication a contract variation may be required. The Provider must be registered with and meet approved quality services in line with The Care Quality Commissions regulations and standards (2009)

The provider will be expected to comply with the clinical governance framework for NHS Dorset and to function under agreed operational and clinical policies.

Clinical Obligations:

- If Statutory/Professional Registration is required it must be maintained at all times.
- The providers must ensure that each clinician takes responsibility for maintaining continuous professional development in order to meet requirements of professional registration
- All Clinicians must work within the boundaries of professional registration and relevant professional Code of Conduct.
- The provider must demonstrate that systems are in place to ensure that competencies are maintained and skills are up to date. The provider must ensure that sufficient numbers and grades of staff are employed in order to provide an appropriate skill mix and to ensure the service can be consistently delivered in accordance with the service specification.
- All staff will ensure compliance to statutory and legal frameworks implementing service developments in a timely manner as new directives are published

3. Service Delivery

3.1 Service model

The service model will ensure that Community Services are delivering the aims and objectives of this specification, that the services provided put the patient at the centre and that a holistic approach is taken to deliver the best outcomes for each individual.

The service model must be flexible to ensure that the service delivery can be developed

working towards and achieving the commissioning intentions within the prescribed time frames.

The Provider will ensure it has a Business Continuity Plan in place so that all staff can respond to a Major Incident when required and that they will support other services and regional areas if required.

The service model will ensure that Community Services are aware of the distinct needs of different groups using their services, and that they address these needs to ensure equity of access and treatment for physical, psychological and social needs.

3.2 Care Pathway

An integrated care pathway (ICP) is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical, psychological or social care experience to positive outcomes.

Within this specification the pathways are focused upon:

- Urgent care
 - Rapid response
 - Step up
 - Step down

The service will ensure that patients are proactively managed both physically and psychologically with an expected date of discharge from all care interventions including active caseloads and bed based services.

Rapid Response: The service will provide rapid holistic assessment and treatment of acutely unwell patients in a community setting including an initial assessment by the most appropriate clinician within a two-hour response time, with appropriate care in place within two hours of the initial assessment if required during core hours (0800 to 2000 to be achieved by 31 March 2012). Outside core hours an urgent and rapid response will comprise telephone advice and home visits for patients requiring care via a call centre able to mobilise appropriately qualified and trained staff. This may be an on-call system to accommodate variations in demand.

Outcomes:

- Response and assessment within 2 hours to requests of urgent unscheduled care
- Appropriate access to required care based on assessed needs
- Timely response to request for facilitated discharge
- Timely discharge from unscheduled care

Step up: The service will manage acute events for patients which previously led to a hospital admission and may include the delivery of advanced nursing practice; social or nursing, psychological/therapeutic intervention such as rehabilitation and/or reablement services that maintain patients at home with an acute need/condition that cannot be met within routine care.

These services can also include the use of short term services that offer 1 to 1 or group rehabilitation services which include social and psychological care needs.

The service can also include the use of step up accommodation where short term residential based rehabilitation services can be delivered when a person may have previously gone into an acute based bed service.

Access to ambulatory day care or bed based services will be via the intermediate care team and will meet the following criteria:

- Ambulatory day care provision or community hospital beds allocated for use of prevention of inappropriate admission to acute care beds or long term residential care
- Medical management of patients is the responsibility of the ward doctor
- Admissions accepted from the following routes:
 - Patients own home (including residential/nursing care)
 - A&E (following a review by medical physician)
 - Emergency medical unit

Outcomes:

- Required services are successfully accessed
- Provision of a wide range of rehabilitation and advanced nursing services including psychological interventions to Step 2 that suit a wide range of patient needs

Step down: The services will provide a range of multi disciplinary services that facilitate timely discharge from bed based services to the individuals place of origin whenever possible and will include the delivery of advanced clinical practice or social care intervention, that supports early discharge and maintains them at home with an acute need/condition that cannot be met within routine care. The service will ensure that patients are proactively and holistically managed (physically, psychologically and socially) with an expected date of discharge from all care interventions including active caseloads and bed based services.

Outcomes:

- Patients are able to return to their usual place of residence
- Ongoing reduction in number of delayed transfer of care to community based services.
- Reduction in number of patients being discharged from community bed based services into long term residential placements
- Timely response i.e. within 48 hours, to requests of step down services

There are a number of other areas that sit outside the above care pathway which are key to the delivery of integrated community services and sit within separate service specifications:

Palliative Care and End of Life General palliative nursing care will be provided for all patients approaching the end of their lives being cared for in the community, ensuring patient choice is promoted and facilitated, working in partnership with the patient, their family and all other relevant professionals to ensure a holistic approach including psychological assessment and needs being addressed.

Enhanced practitioner services; The service will include the provision of specialist practitioners integrated into the multi-disciplinary, multi-agency teams that can provide specialist interventions when needed and who will maintain and lead the competency levels of those generic staff through training, support and guidance.

Outcomes:

- Patients will receive specialist interventions by an appropriate health or social care professional when required
- The service will meet the standards set out within National Service Frameworks
- Care will be provided in an integrated way

3.3 Location(s) of service delivery

The vision is for the service to be delivered within seven localities with seven core intermediate teams however some localities may have outreach hubs in order to cover the large rural landscape of Dorset.

3.4 Days/hours of operation

- Services will be accessible 24 hours a day 7 days per week 365 days a year to provide urgent and end of life care (a separate service specification to be agreed to cover Dorset, Bournemouth and Poole)
- Core service delivery will be from 08.00 to 20.00 7 days a week 365 days a year
- Bed based services will operate 24 hours a day, 365 days a year
- There will be a small number of occasions when a planned intervention will be required outside of core hours and this will be provided by the enhanced intermediate care team

3.5 Referral criteria and sources

During core hours, each locality will operate its own referral/access process (see 3.6 below); this will switch to the SWAST SPOA outside core hours.

Access to bed based services will be via the intermediate care teams

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.

3.6 Referral processes

- The provider should agree systems within each locality/general practice to receive referrals by face-to-face/fax/encrypted email and letter
- Referral to be accepted in a sense of true partnership working with a single assessment framework and professional confidence in handover from one professional service to another
- The referral/assessment should contain the following information:
 - Name, DOB and address
 - NHS Number and the GP practice details
 - Referral number (if given by single point of access)
 - Presenting Complaint
 - Reason for Referral – to provide expectation of service required by referrer
 - What has been provided so far, for example Psychology/counselling support, sick leave, medication, other agencies.
 - Effect on daily living e.g. employment, domestic problems or other effects
 - Current medication
 - Past medical and mental health history
 - Relevant background history
 - Coping methods? Drinking alcohol, avoiding work
 - Patient's expectations and aspirations.

The service which accepts the patient will liaise with the patient and the GP to ensure the patient is seen within target timescales and that the referring professional is aware that care has been initiated.

Following referral, a professional from within the team will undertake a holistic assessment. This initial assessment will include Single Assessment, risk assessment and any additional

Specialist Assessments including psychological as required.

Following assessment, the team will set holistic treatment plans and goals. If input from other specialist services is required ongoing referrals will be made by the team.

3.7 Discharge processes

The provider will ensure that as an individual is accepted on to a caseload or admitted into bed based services they will be provided with an estimated date of discharge. Patients will be discharged from care at the appropriate point on the care pathway.

Patients that require long term care must be referred to the appropriate service with a holistic person centred single assessment plan and the service must be advised of the expected date of discharge from the intermediate care services as soon as that date is agreed.

Patient Reported Outcome Measures should be used to inform service development

3.8 Response time and prioritisation

Referrals must be assessed on the day they are received and triaged appropriately to determine the appropriate response and ensure the appropriate professional/service responds

Urgent: Respond immediately with a maximum of 2 hours to contact and assessment

4. Other

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of Breach</i>

6.1 Activity Plan / Activity Management Plan

6.2 Capacity Review

If required, relevant parts of the Activity Plan and Capacity Review Criteria should be inserted here

7. Prices and Costs

7.1 Price
If required, relevant Prices may be inserted below

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
Non-Tariff Price (cost per case/cost and volume/block/other)*		£		£
National Tariff plus Market Forces Factor		£		£
Reduced Tariff Prices	[For local agreement – set out basis of calculation and if appropriate the actual prices as well as the applicable duration of the agreed prices]			
Total				

**delete as appropriate*