SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a service specification for local populations/systems, to support new surge capacity for predominately older people to recover/ receive rehabilitation or reablement in a care home instead of residing in a hospital bed.

The new care units, to be established in care homes, can be used flexibly and will be suitable for people on discharge pathways 1,2, and 3.

The service will offer the following elements within a care home:

- **Recovery** – Support the person through the recovery phase whilst having access to diagnosis including geriatrician, treatment and prescribing interventions, personal and social care and time for recuperation where appropriate

- **Rehabilitation** - Active therapy led interventions aimed at optimising a person's potential and restoring autonomy where early intervention will be of benefit. Professionally assessed and goal/ outcome orientated and agreed with the individual

- **Re-ablement** - Optimising a person's independence within agreed short term and goal focused care plans. Care provided by generic and specialist health and social care workers working with the enablement ethos. Professionally led assessment, goals setting and monitoring.

These service specifications outline the core expectations for care homes, professionals, and commissioners of the service.

Service name	Winter Framework for short term rehabilitation/reablement/recovery beds in care home settings.		
Service specification number	*Version 1.0*	**Date Approved**	**Review Date**
		20th December 2021	
Status	*Approved for publication 20th December 2021*		

Aim of the Service:

Provide a safe and responsive rehabilitation, reablement and recovery service that supports people to regain independence post discharge.

Provide quality care and support to all residents through a person-centred approach, giving full support to moving people on to more permanent arrangements, where moving back to their home is the first option to be considered. It will be essential to embed a reablement ethos into these units using the expertise of physiotherapist and occupational therapists.

Cohort Definition

People who are ready to leave hospital (under Pathway 1, 2 or 3) with an identified recovery/rehabilitation or reablement need/goal. These people:

- Will not be able to return home directly from hospital, even with community health, social care and/or voluntary sector support
- Will require a period of recovery/rehabilitation/reablement in a 24-hour bedded unit (up to 4weeks) and likely to return home.
- Are medically optimised for discharge and no longer meet the criteria to reside in acute care
- Will have identified recovery/rehabilitation goals that cannot be met in their own homes and have clear outcomes expected following the period of short-term support
- Will consent to admission or if people cannot consent to this then Best Interest Assessment must be completed prior to admission
- Will not require specialist rehabilitation beds e.g., stroke/neuro rehabilitation
- Will not require 1:1 support due to significant cognitive impairment and or behavioural challenges.
- May include those whose needs are unknown but who may not as yet be able to return home.

Estimated LOS (Length of Stay):

- Up to 4 weeks (with some exception that some patients may exceed this timeframe)

Professional/clinical care expectations

Rehabilitation professionals:

- To transfer with a brief therapy plan- functional ability, goals and exercise program if provided in acute
- Therapy initial assessment (Occupational therapy (OT) or Physio) within 24 hours of admission
- Goal setting and therapeutic advice and program handed over to therapy assistants and care home staff- within 72 hours of admission
- Estimated discharge date set within 72 hours of admission
- Access visits and/or home visits to be carried out as required
- Therapy staff to be made available to care homes

Medical Care:

- GP review (where needed) within 72 hours of admission or ACP- nurse practitioner, access to weekly GP follow up/oversight (in line with existing standards in the enhanced health in care home framework), access to pharmacy (if assessment required before 72 hours, this needs to be highlighted to GP).
- Acute trust following patient discharge would need to send medication for patient on arrival at care home (to ensure no further delays).

Nursing Care:

- Aligned community nurse linked to beds and/or Enhanced Nursing Home service to provide support (where the care unit is in a care home without nursing registration)

Care home staff:

- Therapy team to work with care home staff to support development (and ultimately sign off) rehabilitation/reablement competencies

Social Care:

- A social worker within 48 hours of admission and initial assessment completed (preferred “allocated staff covering specific care homes/units) and care planning support to ensure timely transfer to the persons home environment

Communication/transition along the discharge to assess (D2A) pathway:

- Person to be discharged and family/carers to be updated and included in discussions regarding their care and discharge planning
- Person to be discharged and family/carers meetings to be arranged as required- suggested minimum of once during pathway 2 stay
- Inform person to be discharged and family/carers on where they can find further information on intermediate care. For example the NICE quick guide to intermediate care which provides links to patient groups.
- Weekly MDT meeting to include therapists and social worker
- All professionals involved, the person to be discharged and family/carers to be aware of estimated date of discharge (EDD) and goals for discharge
- Transfer of care leads (transfer of care hubs) manage pathway and are pivotal in determining patients' needs

Outcomes Measured:

- Discharge destination
- Length of stay (LOS)
- Patient and carer/family feedback
- Outcomes including any functional outcome measures e.g. Barthel

NHS Outcomes Framework Domains & Indicators

		Y/N
Domain 1	Preventing people from dying prematurely	Y
Domain 2	Enhancing quality of life for people with long-term conditions	Y
Domain 3	Helping people to recover from episodes of ill-health or following injury	Y
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Y

Service Specific Outcomes

Reasons for Admissions:

- Joint working within the service and with other agencies and partnerships

- 90% patients with a length of stay (in beds and on caseload) of under 4 weeks
- Training programme in place supporting any care home staff working with people in the care unit.
- Beds to be maintained at 90% or over occupancy
- Beds available for the person to be transferred into on the day they no longer meet the reasons to reside criteria in hospital – coordinated and manged by the transfer of care hubs in hospitals
- Trusted assessors arrangement utilised with hospital transfer of care hubs, in line with CQC guidance[1], to avoid the need for registered care home mangers having to assess the person in acute care
- Full MDT assessment to be completed within 2 operational days of admission onto caseload/bed- target 100%
- Individualised goals and care plan to be agreed with patient within 2 operational days of admission to caseload /bed. - target
- 90% of patients partially (at least 50%) achieving their goals
- 90% patients assessed using a validated clinical outcome measure for rehabilitation tool to be decided by the Provider
- Patient satisfaction existing measures used in your system. (i.e. FFT- Friends Family Test).
- Operational day defined as Monday to Friday.

[1] 20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf (cqc.org.uk)

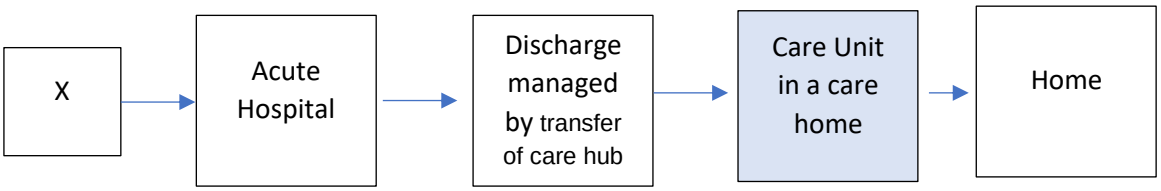
Service description

Service Model

- To promote activity, increase strength, endurance, independence and ability to manage activities of daily living by providing access to therapies with a focus on restoring function.
- These include functional practice opportunities, wellness and self-care activities that support the return of patients to their previous living environment or other appropriate community environment.

Pathways

- Overall pathway- The general flow of service users is illustrated in the diagram below.



Essential Service Components:

The Provider shall:

- Provide access for MDT staff to the recovery/rehab/reablement beds and provide full time short stay person centred care for referred clients.
- Ensure the rooms will be made available for admitting clients 7 days a week, during the contract period, including bank holidays. Admission times will be dependent on the needs and safety of each individual and are expected to be within 8am – 6pm to facilitate timely discharges.
- People who are eligible for care will have varying levels of dependency and are likely to have both physical and low level mental health needs. The Provider will be expected to always have suitable staffing levels available to meet these needs.
- Not restrict access to the beds, unless there have been emergency restrictions placed upon the home by CQC.

- Comply with all Department of Health and Social Care, UK Health Security Agency and Care Quality Commission requirements where infection control measures are required.
- Ensure outcomes specified within an individual's care plan are met.
- Ensure that care is delivered in a manner which will maximise the independence and wellbeing of the client.
- Admit clients to the facility on the day they no longer meet the reasons to reside criteria in hospital – coordinated and manged by the transfer of care hubs in hospitals
- Use the trusted assessors in the hospital hubs to enable the care home manager to fulfil the regulatory requirements to assess the person prior to admission to the care home
- Be required to deliver double assist care. The Provider shall be able to evidence how they will meet this requirement.

Eligibility Criteria

- The service will be provided to individuals with care and support needs who are medically fit in that they no longer meet the criteria to reside in an acute general hospital but would benefit from short term accommodation based care to improve their functioning and to allow for further assessment.
- Have a physical disability which can be accommodated
- Admission times will be dependent on the needs and safety of each individual and are expected to be within 8am – 6pm, seven days a week to facilitate timely discharges.

Essential equipment and/or facilities

- People should have mental capacity and not Deprivation of Liberty Safeguards (DOLS).
- Wi-fi access for patients and clinical staff.

Other exceptional requirements

This contract is not suitable for the following:

- Palliative care patients
- Clients who have a life expectancy of 6 weeks or fewer.
- An individual who has tested COVID19 positive before discharge, unless the individual has completed the required isolation period and is therefore considered to be no longer contagious.

- Planned respite/replacement care

Links to other key documents

NICE guidance: https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/understanding-intermediate-care

Understanding intermediate care, including reablement | Quick guides to social care topics | Social care | NICE Communities | About | NICE

CQC guidance on Trusted Assessors:
20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf (cqc.org.uk)

Specification 1 -– Equipment List

Type of equipment	Responsibility to supply
For administration of medicine	
For administration of oral medicine eg measures, medication boxes	Provider
For administration of rectal medication eg gloves	Provider
For administration of medication by injection	Provider
Bathing equipment	
Range of bath seats	Provider
Range of bath boards	Provider
Electric/manual bath lift:	Provider
Range of chairs	Provider
Range of shower stools and shower chairs with or without wheels	Provider
Specialist Shower Chairs (eg Tilt-in-space)	NHS
Beds	
General beds under risk-management	Provider
Standard hospital beds – variable height and profiling	Provider
Standard electric profiling	Provider
Non-standard beds eg for people with extra care needs –additional width or length e.g. with bariatric needs	NHS
Bed attachments for risk management	Provider
Range of back rests	Provider
Rope ladder	Provider
Range of bed raisers	Provider
Mattress variations –single	Provider
Hollow core fibre overlay (for comfort)	Provider
Over bed trolley table	Provider
Lifting pole	Provider
Bed Rails: divan/padded.	Provider
Chairs / Seating	
Range of high seat chairs- varying height and width	Provider
Chair blocks and raisers	Provider

Type of equipment	Responsibility to supply
Non- customised, non-adjustable seating, e.g. riser recliner chairs- electric, fixed angle seat and back rest	Provider
Adult's individualised complex customised seating including variable tilt-in-space chairs	NHS
Help with nutritional status	
Peg feeding equipment (EL (95) 5)	NHS
Peg feeding consumables	NHS
For intravenous feeding and transfusion	NHS
Equipment eg plate accessories	Provider
Range of feeding equipment including adapted cutlery	Provider
Environmental support	
Helping hand	Provider
Trolley	Provider
Perching stool	Provider
Dressing Aids	
Dressing Aids Stocking / tights aids	Provider
Long- handled shoe horn	Provider
Wheelchairs	
Push wheelchairs, standard transit chairs, and wheelchair cushion	Provider
NB: Wheelchairs and accessories for permanent and substantial usage, following individual assessment where appropriate; Self propelled and manual chairs, indoor and indoor/ outdoor electric. All subject to current Wheelchair Services criteria.	Provider
Wheelchair accessories	
Ramps	Provider
Nursing equipment	
Venepuncture	
Vacutainer bottles for blood tests	NHS
Syringes and needle	NHS

Type of equipment	Responsibility to supply
Catheterisation	
For management of catheterisation eg bag, stand, packs	Proivder and via prescription
Prescription for catheters and bags	NHS
Dressings	
For procedures related to aseptic and clean dressings	Provider and via prescription
Nursing procedures	
Routine nursing procedures, eg, testing urine, BP, BM (glucometer)	Provider
Moving and Handling Equipment	
For lifting and manual handling under health & safety at work act, e.g. hoists, slings- varying sizes and styles, transfer boards, glide sheets	Provider
Hoists: ceiling tracks	Provider
Hoists: toileting	Provider
Standard Slings, including toileting and full slings in a range of sizes	Provider
Individual specialist slings	NHS
Standing frames/ hoist	Provider
Stand aids	Provider
Standing turntable	Provider
Prevention therapy and management of pressure ulcers	
Mattresses: static with stretch vapour permeable cover (e.g. Low zone)	Provider
Static Air filled mattress overlays (e.g. Repose)	Provider
Static Foam replacement mattress- for use with non profiling bed (e.g. MSS premier)	Provider
Static Foam replacement mattress- for use with profiling beds (e.g. MSS glide)	Provider
Very High Risk Foam replacement mattress (e.g. MSS glide)	Provider
Mattresses: dynamic	
Deep cell alternating pressure mattresses replacement specific to risk e.g Talley Quattro plus/prime	Provider

Type of equipment	Responsibility to supply
Low air loss replacement mattress (e.g Breeze)	Provider
Mattresses for NHS Provided non-standard beds	NHS
Heel Protectors (e.g. repose heel trough)	Provider
Pressure relieving Cushions	Provider
Foam for at risk/ low risk	Provider
Foam / gel for medium / high risk and treatment	Provider
Foam / gel / clay for high / very high risk and treatment	Provider
Electric alternating cushions e.g Base cushion	Provider
Respiration	
For maintenance of respiration eg suction units	Provider
Oxygen cylinders	Provider
Oxygen administration consumables	Provider
Simple nebulisers	Provider via prescription
Resuscitation equipment (eg mouth to mouth)	Provider
Pulse oximeters	NHS
Nebulisers and humidifiers (eg for ENT, CPAP, BIPAP)	NHS
Sensory/ hearing	
Vibrating clocks	Provider
Flashing fire alarms	Provider
Flashing door bells	Provider
Mini comms	Provider
Hearing loops	Provider
Sensory/visual	
Range of canes	Via Adult Social Care Contact Centre
Telecare	
Range of alarms	Provider
Range of monitoring equipment	Provider
Toileting	

Type of equipment	**Responsibility to supply**
Fracture pan (bed- pan)	Provider
Range of commodes: standard	Provider
Toilet seats: standard raised 2”, 4”, 6”	Provider
Free standing/fixed toilet frames & wall mounted rails	Provider
Urinals/ bottles	Provider
Urinals/ bottles: non-return valves	Provider
Special sheets	Provider
Continence pads	Provider
Commodes: non - standard	Provider
Specialist Commodes (e.g. Tilt-in-space)	NHS
Falls	
Hip protectors	Provider
Walking Aids	
Range of walking aids appropriate to individual needs	Provider
Therapy Equipment	
Equipment required to deliver therapy/rehabilitation, including: • Parallel Walking Bars • Rehabilitation Steps • Therapy Couch • Small equipment required for exercise/rehabilitation	Provider