Short Term Residential Bed Based Services Specification

1. Introduction and Background

The Authority's vision is to enable people to live independently and as healthily as possible with the right level of care and support for themselves and their informal carers with prevention, early intervention and promoting independence at the heart of our approach.

Our approach will put the Individual at the centre of every decision and build on their existing strengths and circumstances to help keep them safe and living independently for as long as possible, whilst also being mindful of their wishes and choices.

- We will offer care and support to prevent as many avoidable hospital and care home admissions as possible.
- Where a hospital stay is unavoidable, we will ensure care and support (including equipment) is offered to enable the Individual to recover quickly and safely at home, and assessments for any ongoing care and support will take place in the Individuals own home.

Wherever possible, Individuals should be supported to be discharged back into their own home and their assessments for ongoing needs undertaken there. However, some Individuals are unable to return directly home and may still need a period of on-going assessment in a safe and monitored environment.

The Short-Term Residential Bed Based Service is a short-term care option usually lasting around 1 – 4 weeks in a care home environment based upon the Individual's needs, however, at times duration could be longer it is anticipated this would be a maximum of 6 weeks. This Service puts the Individual and their families at the centre of the decision, and they are supported and led by a named social worker to get the best possible outcome. The allocated social worker will ensure that clear information is given regarding the persons further care needs and what discharge process will be followed from hospital.

1.1 **The Service**

1.2 The Service aims to facilitate a safe and prompt discharge from hospital upon a person being deemed medically ready for discharge. The Service also aims to reduce the Individuals stay in hospital by offering a period of assessment post discharge to ascertain an Individuals ongoing need.

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1.3 Working to a home first ethos, a discharge to the Individual's home would always be the first option. However, some people may still require a period of ongoing care and support in a 24 hour care home environment prior to returning home, referred to as a 'Short Term Bed placement'. Discussions will be had with the Individual and their family to ensure they are in agreement with this.

1.4 The Service Provider will support Individuals who may need a period of Recouperation or Rehabilitation with an emphasis upon a re-abling approach which requires the Service to support Individuals to optimise their ability to self-care.

i. Recouperation will be provided for Individuals who cannot directly return to or remain safely in their usual place of residence and require a period of care and support as part of recovery from illness or exertion which is anticipated to be short term.
ii. Rehabilitation will be provided for Individuals who cannot return to or remain safely in their usual place of residence. The Individual will have been assessed by a therapist or other professional in a multi-disciplinary team as being likely to benefit from a short period of bed-based rehabilitation with clear therapy goals identified that will be expected to be worked towards achieving that cannot as otherwise be managed in the Individuals own home.

1.5 The Service Provider will accept admissions from both a hospital and community setting.

1.6 The Service Provider will work with the Authority and NHS staff to promote an Individual's independence whilst in a short-term bed placement through a re-abling and strengths-based approach.

1.7 The Service Provider will aim to achieve an outcome of the Individual returning to their usual place of residence where possible.

1.8 The Service is for Individuals whose ordinary residence is within the Local Authority boundary of Lancashire. If these placements continue as either short term care or long term care the allocated social worker will confirm the funding arrangements.

1.9 The Service Provider will develop close connections with the Authority in ensuring that hospital discharge is prompt, and the Authority is kept up to date regarding the Individual's progress within a Short-Term Bed placement.

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1.10 Referrals for the Service will be made by the Authority or an agreed NHS Team upon the Individual being deemed medically ready for discharge. The referral will include all information presenting to the Individual's needs and this will be on a trusted assessor basis (typically relying on information from discharge teams in hospital).

1.11 The Service Provider will make all reasonable adjustments to support the diverse needs of adults in Lancashire who access the Service. The Service is inclusive of people who may lack Mental Capacity as well as people who may have existing physical health and/or mental health conditions. The Service Provider will identify and work alongside, other services and professionals to ensure all needs are met where reasonably possible to do so.

1.12 The majority of Individual's accessing this service will be over the age of 65 years, however there may be a requirement for Individuals under 65 to access the Service.

2 Service Availability & Capacity

2.1 The Service will be provided 7 days a week, 24 hours a day, 52 weeks per year. The Service Provider must have adequate Staff available to meet the requirements of the contract.

2.2 The Service Provider must have staff available to respond to all referrals within two hours of receipt and be able to admit an Individual into a bed within 24 hours of accepting the referral.

2.3 The Service Provider must use its best endeavours to ensure there are sufficient Staff to cover instances of sickness and annual leave to ensure that the Service is consistently provided to a high standard throughout the year.

2.4 The Service Provider must provide evidence of their contingency planning for Staff absence and for ensuring service continuity. The Service Provider will work with the Authority to ensure the contingency plans are to the satisfaction of the Authority.

3 Referrals, Service Access and Service Pathway

3.1 Once ICAT/CATCH have deemed the Short-Term Bed placement is appropriate, the referral will be sent onto the Care Navigation Team. The referral information will include:

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1) Name
2) Address
3) Telephone Number
4) Date of Birth
5) Reason for referral/ presenting needs
6) Current Medical Conditions
7) Any known Safeguarding issues
8) Any known Mental Capacity issues including capacity to agree to referral
9) Next of Kin
10) Current care arrangements (formal care, family carers, etc)
11) Any moving and handling equipment or techniques in place or to be used by the Service Provider

3.2 ICAT/CATCH will review the referral information via a 'Trusted Assessment' to determine if a Short-Term Bed placement is required. The ICAT/CATCH Teams will utilise the trusted assessment to determine the most appropriate placement to best support the Individual.

3.3 Once Care Navigation receive this referral, they will screen, allocate and advertise the request within 1 hour. The Service Provider must respond to Care Navigation within a 2 hour time frame if they are able to accept the placement.

3.4 Once the Service Provider has confirmed they are able to accept the placement, the Service Provider must admit the Individual into the bed within 24 hours.

3.5 At all times, the Service Provider must work in line with the Mental Capacity Act 2005. A Mental Capacity Assessment would be completed prior to the decision to discharge the person and to ensure they consent to the placement. The Service Provider will need to follow the MCA principles in delivering care to the person during the assessment period, including any consideration of DOLs.

3.6 Once the Individual has been admitted to the Care Home a member of the ICAT/CATCH team (or the agreed NHS team) will complete an initial review of the Individual's needs within 72 hours of their admission. The Service Provider will be integral to this review and will be expected to provide an overview of the person and any progress they have made or otherwise since their admission.

3.7 Upon completion of the initial review, the ICAT/CATCH team will make recommendations in supporting to improve the Individual's independence

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with the intention of returning home or to their usual place of residence. These recommendations will include, but are not limited to:

- An occupational therapy exercise programme
- The use of equipment
- A referral to the district nurse
- A physio therapy exercise programme
- Any ongoing reablement of daily living tasks

3.7.1 Trusted Assessments will be monitored by the Authority to ensure the information can be relied upon to determine the immediate needs of Individuals and expectations will be set out on what the trusted assessment should contain.

4 Objectives and Principles of the Service

4.1 Key Objectives & Supporting the Person to return home

4.1.1 The Service Provider will enable the Individual to retain as much independence as possible, respect personal dignity and maintain a good quality of active life.

4.1.2 The Service provider will ensure that the Individual remains at the centre of all care and support planning, delivery and decision making.

4.1.3 The Service provider will ensure that risk assessments are completed to ensure the safety of both the Individual and the care staff.

4.1.4 The Service Provider will support the Individual through a period of recovery and recouperation following a hospital stay or from their community setting.

4.1.5 The Service Provider will support the positive wellbeing of the Individual(s) they are supporting.

4.1.6 The Service Provider will assist the Authority in ensuring requirements under the Care Act are met insofar as they relate to the Services.

4.1.7 The Service Provider will assist the NHS with any requirements regarding assessments for fully funded continuing health care.

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4.2 **Key Principles**

The Service Provider must:

4.2.1 Promote each person's dignity, privacy and independence.

4.2.2 Acknowledge and respect the gender, sexual orientation, age, ability, race, religion, culture and lifestyle of people including Individuals.

4.2.3 Recognise the individuality and personal preferences of Individuals in their care.

4.2.4 Be consistent in providing a high-quality service which is person-centred, strengths-based, flexible, reliable and responsive.

4.2.5 To support Individuals to regain/maintain their links within the community.

4.2.6 Provide comprehensive training to care staff to ensure that they have the knowledge and skills and that they are confident in providing support to Individuals accessing the Service.

4.2.7 Ensure Staff provide the Service in a way that acknowledges and respects Individuals and complies with the Equality Act 2010.

4.2.8 Provide support for informal carers and recognise the rights and involvement of other family members.

4.2.9 Acknowledge that Individual's have the right to take risks in their lives and to enjoy a lifestyle of their choosing.

4.2.10 Work in line with the five principles of the Mental Capacity Act 2005 and the associated code of practice, which are:

a) Principle 1: A presumption of capacity
b) Principle 2: People being supported to make their own decisions.
c) Principle 3: A person is not to be treated as unable to make a decision merely because they make an unwise decision
d) Principle 4: Best Interests
e) Principle 5: Less restrictive option.

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5 The Service Provider will

5.1 Develop and operate a risk-based framework that supports the safe delivery of the Service.

5.2 Take a positive risk-based approach in consultation with the Authority that enables a safe Service to be provided.

5.3 Support a robust and streamlined referral route into the Service that is responsive.

5.4 Ensure Staff receive regular and meaningful supervision sessions during which their performance is appraised.

5.5 Ensure that the wellbeing of Individual's in their care is supported at all times.

5.6 Work in partnership with health and care professionals to deliver any agreed rehabilitation or enabling programmes for the person during their Short-Term assessment period.

5.7 The Service Provider must co-operate with the Authority in minimising the provision of double-handed support. This can be done through the use of specialist moving and handling equipment (e.g. ceiling track hoists, bed positioning systems) and techniques provided by the Authority or the NHS where it is considered safe as part of a suitable and sufficient Individual risk assessment undertaken by a Competent Person, and the Care Worker has received the necessary training and is deemed competent to safely carry out the moving and handling alone, or with a willing and able informal carer.

5.8 Ensure that any informal carers or family/ friends of an Individual are included in all decisions and discussions about the Individual's care needs. Any ongoing support must also be communicated to the Individual and their family to ensure all parties are kept informed and up to date with progress of the person and any changes.

5.9 Contribute to and participate in, any reviews and assessments of the Individual as required.

5.10 Alert the ICAT/CATCH team as soon as possible to any change in needs of the Individual that may affect the ability of the provider to support their level of care.

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5.11 Recognise that Individual's may be more anxious on admission and their needs may fluctuate in the first few days on admission and ensure that they provide welcoming and reassuring support.

5.12 Referrals should be made to Independent Mental Capacity Advocates where appropriate.

5.13 As we move into an increasingly digital world, we want people who have additional support needs to have every opportunity to feel connected and immersed with a digital offer. Service Providers will refer people to the TEC (Technology Enabled Care) service when appropriate and propose creative solutions to increase independence, connectivity with health providers, safety, privacy, choice and control for people utilising the very best in tech enabled support. Successful Service Providers will keep up to date with the latest innovations and will proactively promote new technology.

6 Outcomes of the Service

The Service shall achieve the following outcomes:

6.1 Ensure the Individual remains at the centre of all care and support planning, delivery and decision making.

6.2 To ensure Individual's in Lancashire are:

a) Safe, secure and connected to their local community.
b) Maximise their potential, remaining health and feeling well.
c) Living as independently as possible in their own home, or close to home.

6.3 Increase the independence of Individual's admitted into a Short Term Bed placement by following plans implemented by the Authority and health partners.

6.4 Improve health and social care outcomes.

6.5 Improve the wellbeing and morale of Individual's and provide them with a sense of purpose whilst in the Short-Term Bed placement.

6.6 Work with the Authority in developing and improving the Service.

6.7 Risk assessments will be completed to ensure the safety of both the Individual and the care staff.

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6.8 The Service will maintain strong links with partners including, but not limited to:

a) Other care companies
b) Local Authority colleagues
c) External educational and training organisations
d) Adult Social Care
e) NHS care providers
f) Local Authority and NHS employed occupational therapists and physio therapists
g) Voluntary sector organisations
h) Community health services

7 Planning and Management

7.1 The Service Provider must identify a suitably skilled and qualified person or persons with full knowledge and understanding of workforce issues pertaining to the delivery, to be responsible for workforce planning for the Service.

7.2 The Service Provider must develop workforce plans to be updated at least annually and more often as appropriate to ensure that arrangements are in place to maintain the workforce capacity and capabilities required to deliver the Service for the duration of the contract.

7.3 The Service Provider must develop specific plans for the following:

7.3.1 Staff recruitment and retention
7.3.2 Management of Staff sickness and other absences
7.3.3 Staff learning and development.

7.4 The Service Provider must develop separate documents for the following:

7.4.1 Succession plans for key management posts and/or posts requiring scarce skills.
7.4.2 Recruitment and retention of minority groups.
7.4.3 Specific plans for issues identified organisationally.

7.5 The Service Provider must have in place an effective Staff sickness absence management and monitoring system.

7.6 The Service Provider must have plans in place for recruitment of additional Staffing resource should the need arise to increase the contract levels.

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8 Staff Supervision and Annual Appraisals

8.1 The Service Provider must ensure that all Staff have regular, planned and documented supervision sessions.

8.2 The Service Provider must ensure that all Staff have a documented annual appraisal.

8.3 The Service Provider must ensure that Staff know when and how to raise an issue, comment, concern or complaint with their manager or supervisor or another member of the organisation they work for.

9 Reporting Requirements

9.1 The Service Provider will be required to make use of the Authority's agreed recording system to capture activity in relation to the progression of referrals.

9.2 The Service Provider will provide a monthly report outlining the activity within their service. This will include but is not limited to:

I. Timescale from referral to admission
II. Dependency level on admission
III. Dependency level on discharge
IV. Progression
V. Length of stay
VI. Outcomes

9.3 All reports will be developed and agreed between the Service Provider and the Authority and will be reviewed regularly.

10 Partnership Working

10.1 Partnership working is at the heart of successful delivery of the Service. This applies to the relationship between the Authority, the Service Provider, and any other external partners. The Service Provider must work in partnership with other organisations or individuals including but not limited to those listed below:

10.1.1 Adult Social Care
10.1.2 Healthcare providers
10.1.3 Social care providers
10.1.4 NHS
10.1.5 Voluntary sector organisations

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10.2 Attendance at key meetings is essential to working in partnership with stakeholders and it is expected that the Service Provider will ensure attendance at key meetings where their attendance is required is maintained for the duration of the contract.

10.3 The Service Provider will work in partnership with the Authority to make improvements/changes to the Service where appropriate to better meet the needs of older vulnerable people.

11 Training

11.1 The Authority may from time to time offer training to Service Providers. The Service Provider will be expected to ensure they are represented at these training sessions and that this is then disseminated to all Staff within their care home.

12 What the Authority will do

12.1 In order to ensure the Service reaches its maximum potential, the Authority will apply the following principles:

i. To work in partnership with the Service Provider
ii. Review each individual admitted into a Short Term Bed within 72 hours of admission.
iii. Maintain regular contact with the Service provider in order to support the person admitted to the Short Term Bed to maximise their independence with the goal being to return home.
iv. Work with the Service Provider to resolve any issues and overcome barriers.

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