Barnsley Clinical Commissioning Group

Putting Barnsley People First

Service Specification

The new service to deliver integrated Intermediate Care functions in Barnsley

Service Specification No.	FINAL VERSION
Service	An integrated service designed to support older people and adults at a time of transition in their health needs and who require extra support to help them return home from hospital or to avoid them going into hospital. An enhanced service offer for those whose healthcare needs are best met out of hospital.
Executive Lead	Brigid Reid Chief Nurse
Commissioner Lead	Jayne Sivakumar Head of Commissioning and Transformation
Provider Lead	Integrated Delivery via an Alliance Contract
Period	June 2017 - TBD
Date of Review	

1. Population Needs

National/local context and evidence base

1.1 National Context

Intermediate Care and re-ablement services are a key plank of government healthcare policy to provide health and care closer to home. The £5.4bn Better Care Fund and the New Models of Care agenda set out in the NHS 5 Year Forward View, NHS England 2014; reflect the ambition for integrated service planning, commissioning and delivery of high quality seamless services to service users. For Local Authorities, the Care Act, 2014 puts the 'wellbeing principle' at the heart of their care and support functions.

The move away from competition within the health system to more integrated models of care (STPs and place based planning) provides an exciting opportunity to deliver more co-ordinated services to patients, improve quality, develop new models of care; improve health and wellbeing; and improve efficiency of services. Collaboration with other services and sectors beyond the NHS is the key to deliver on the broader aim of improving population health and wellbeing – not just on delivering better quality and more sustainable health care services.

1.2 Local Context

1.2.1 Barnsley CCG Strategic Strategy

Barnsley's CCG Strategic Strategy 2014 to 2019 (refreshed 2015) provides the local rational and commitment to transforming health and care services in Barnsley, to ensure patients receive the best possible care.

The strategy states that:

"together (with our partners) we will make significant steps forward in transforming health and care services in Barnsley and particularly make progress against the commitments set out in the NHS Five Year Forward View and towards our long term ambitions to move care closer to home.

This will include:

- transforming the models for service delivery across health and care in Barnsley
- focusing on self-care, by promoting universal information and advice, and sign posting people earlier to a range of community based support
- Combining earlier intervention with greater use of short term / targeted interventions".

1.2.2 Primary Care Commissioning

The CCG is committed to developing primary care at scale in line with the out of hospital strategy. There is an aim to develop the idea of primary care teams, recognising under the auspices of primary care the community nursing, physiotherapy, mental health, and occupational health functions amongst others. This concept is vital to unlocking the solution to workforce challenges; more integration and joint working.

1.2.3 Multi Specialist Community Provider

This Intermediate Care Specification reflects the integrated working of the MCP model. Barnsley CCG has made a commitment to developing and implementing new models of care delivery and is currently in the process of setting up an Accountable Care Organisation with key healthcare partners.

1.2.4 Place Based Joint Working

There is an ongoing commitment to build on the good work already being done through the BCF to help provide care and support to the people of Barnsley, in their homes and in their communities, with services that:

- co-ordinate around individuals, targeted to their specific needs
- maximise independence by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing

- prevent ill health, reducing levels of CVD, respiratory conditions and mental health
- improve outcomes, reducing premature mortality and reducing morbidity
- improve the experience of care, with the right services available in the right place at the right time
- through proactive and joined up case management, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health

1.2.5 Local Health Needs

The mid-2013 registered population of Barnsley was estimated to be 236,000. The health of people in Barnsley is generally worse than the England average. Deprivation is higher than average and in 2012, 34.4% of adults were classified as obese, which is worse than the England average.
There are currently around 42,800 people aged 65+ living in Barnsley, making up 18% of Barnsley's population. The proportion of Barnsley residents aged 65 and over is projected to increase to 20% of the population in 2021. It is anticipated that this will lead to an increase in the number of people living with and dying from long-term conditions.
The total population in Barnsley aged 65+ and living alone is projected to increase to 22,353 by 2030, and those aged 65+ providing 50+ hours of unpaid care to a partner, family member or another person is projected to increase to 4,105 by 2030.

1.2.6 Intermediate Care – The Evidence Base

Intermediate Care has evolved over the past two decades and has done so in response to a variety of different pressures. Since the development of Intermediate Care in the early 2000's a plethora of research and evidence is available to support the improvement, development and delivery of Intermediate Care Services.

This service specification has been written taking into consideration the research and evidence available on Intermediate Care and has also taken the learning from the previous four years 'National Audit of Intermediate Care'. The references and bibliography are listed in the Service Specification appendix.

This new service will be based on a set of values and principles that were agreed upon by stakeholders and elaborated on further during the development of this specification.

1.2.7 Intermediate Care in Barnsley – Current Position

The aim of the current Intermediate Care Service in Barnsley is to rehabilitate patients following an episode of illness or injury. The majority of patients are 'stepped down' into the service from acute care. Very few are 'stepped up' from their own home. The current service provision encourages multiple referrals to exit the hospital and leads to inappropriate use of services.

The acceptance and exclusion criteria into the existing service are limited to rehabilitation which does not reflect the patients who need extra support and care to avoid an admission or to ensure a timely discharge from an acute hospital bed.

Evidence from the current Intermediate Care Service highlights that some patients do not fit the current intermediate care criteria because they have no rehabilitation needs but still require extra support at a time of transition in their health and support needs i.e. requiring a period of recuperation.

There are also patients who require a period of recuperation following an acute illness or injury before they start rehabilitation.

Experience learnt from the existing Intermediate Care Service is that the needs of patients change and change quickly. A referrer's assessment of a patient's need in the acute trust can quickly change when they arrive at a 24 hour bed based facility for rehabilitation or indeed when they arrive in their own home following discharge.

Information from the Intermediate Care Service also shows that some patients who are referred to a rehabilitation bed end up only requiring recuperation for a short period of time and some patients who have been moved to a recuperation bed actually end up requiring rehabilitation.

Furthermore, access to reablement is perceived as a separate strand of the service which is sequential and requires another referral. It is known that patients remain within the Intermediate Care Service much longer than needed and not necessarily moved on to reablement and other services. The current arrangements for these different cohorts of patients (compounded by different funding streams) make it difficult for practitioners to navigate the system which in turn fragments patient care.

1.2.8 Intermediate Care in Barnsley – Future Position

Current models of intermediate care are based on evidence and guidance from the early 2000s onwards and may have not kept up with the changing needs of our local populations and to the current/future financial pressures on the health service.

Looking at the current intermediate care offer in Barnsley, one could argue that patients who do not require an acute hospital bed but require extra support or require support to stay at home fit a model of care that is still classed as intermediate care.

Therefore, this new service aims to enhance the current intermediate care offer by extending and enhancing the scope of the service to include access to recuperation beds for those patients who need this level of intervention with the aim of timely transition of patients between the different components of intermediate care and brokering care from other suitable services i.e. Shared Lives, Reablement (Independent Living at Home) and Support to Live at Home.

The offer will also be extended to those who are able to stay at home but require enhanced support at home which goes over and above the healthcare services provided in the community (universal offer).

It is an expectation that the movement of patients between services will be seamless and timely by ensuring active case management, excellent forward planning and care brokerage. RightCare Barnsley's role will be the key going forward and is explained further in section 3.3 (page 10) of this Service Specification.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Locally defined outcomes

An outcome is defined as a health and/or social gain experienced by a person with an illness, as defined from the person's, rather than the system or clinician's perspective (NHS Confederation, 2014).
By implementing this service NHS Barnsley CCG will achieve the following outcome:

"Patients are more supported and more in control of their condition and care, enjoying independence and quality of life for longer".

The specific Intermediate Care outcomes, against which the success of the service will be measured, will be defined by the CCG, within timescales defined by the CCG. Outcome measures will be relevant to the full episode of care.

The process measures, against which integrated working with primary care and other health and social care services will be assessed, will be defined by both the CCG and the provider together, within timescales defined by the CCG.

3. Scope

3.1 Aims and objectives of the service

- Focus upon the needs of the G.P practice populations it serves within individual locality areas
- Ensure that a spirit of integration and 'can do' is central to its ethos of delivery and foster excellent relationships with primary care
- Transform the classic task based approach to liberate capacity and autonomy, promote effective case management and care brokerage
- Provide a responsive service to people's wishes and choices and ensure that care provided delivers a positive experience as well as the best patient outcomes
- Provide collaborative patient care in the context of the wider multidisciplinary team across primary, secondary and social care as well as the independent and voluntary sector and specialist nursing teams
- Provide safe, high quality, culturally sensitive therapy and nursing care for those people receiving intermediate care
- Provide holistic care for all adults referred to the service, designing and delivering personalised care plans to meet individual health needs
- Support the reduction of admission and re-admission by proactively 'stepping up' patients who require extra support at any given time
- Ensure that access to all elements of the Intermediate Care Service including responding rapidly to an urgent request to avoid an admission. This must be available 24 hours a day 7 days a week and 365 days a year

3.2 Service Description

3.2.1 Intermediate Care is a continuum of integrated services for assessment, treatment, rehabilitation and support for older people and adults at a time of transition in their health and support needs.

The scope of this new service is wider than what 'intermediate care' in Barnsley has historically delivered and includes both rehabilitation and recuperation. It is designed to ensure that:

- Following an acute hospital admission a patient returns and remains in their normal place of residence
- Those at home requiring extra support to prevent a hospital admission receive the right care and support to remain at home

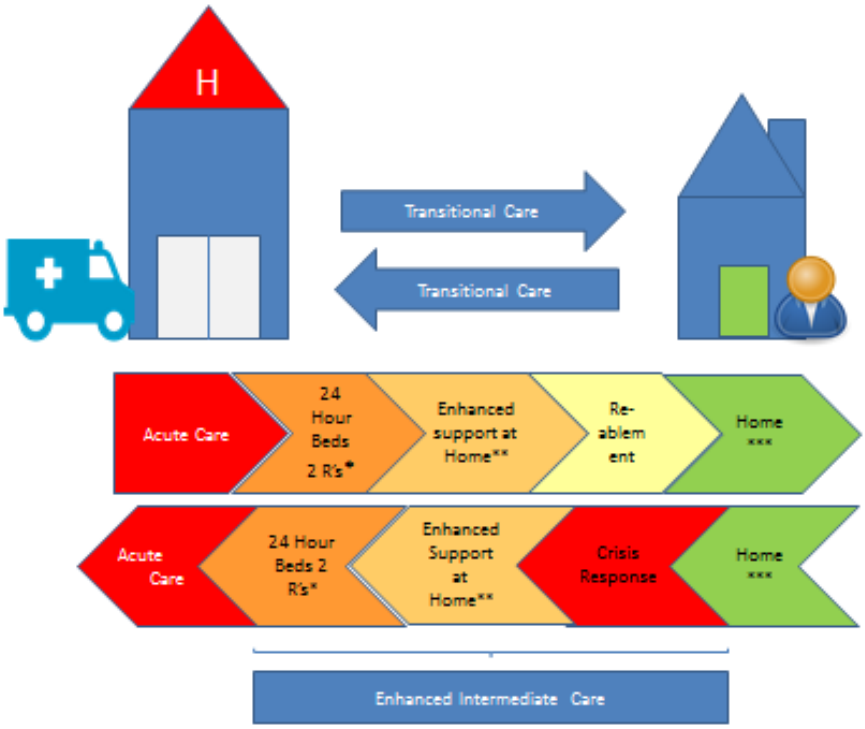
RightCare Barnsley (Care Co-Ordination Centre) will broker the right level of intervention depending on the needs of the patient at that time. This will include 24 hour beds for rehabilitation and recuperation and 'virtual' bed base support in a patient's own home via enhanced support at home

The new service is based on different levels of support and intervention which will depend on the needs of the patient at any given time.

It can be described as a series of interventions aimed to support a person's recovery from an illness or injury. Fluidity between the different levels of support is required to ensure the right care is received.

The following illustration aims to demonstrate this continuum of care and the scope of the service.

3.2.2 Strategic context



2 R's - Recuperation beds and rehabilitation beds in various settings depending on the patient's needs
***Enhanced support at home which goes over and above the services provided in the community*
****Short/long term home support which may be required from Community Nurses, Therapists and domiciliary care (Support to Live at Home Service).*

3.2.3 The new service will be based on achieving outcomes; the time to do this will vary but this is likely to be 6 weeks or less with *justified* exceptions to episodes of care that are longer than this.

The service will be accessible 24 hours a day 7 days a week and will include both step up and step down transfers and interventions.

Each episode of care will consist of assessment, treatment; rehabilitation and/or re-ablement that address a recognised health need - personalised on the needs of the patient.

Older people should never be sent straight home from hospital or to permanent places in residential or nursing homes without proper consideration having been given to rehabilitation.

Following admission into the service the individual's care will be agreed within 24 hours and a lead care practitioner identified.

Robust protocols for information sharing will be developed to support care transitions such as admission, discharge and between the different components of the service.

There should be a wide range of flexible, effective and evidence-based interventions available, and people should be able to receive as many as their needs require concurrently or sequentially without 'leaving' the service.

3.2.4 Crisis response will be available 7 days a week to rapidly respond to patient needs to avoid an admission, readmission and to support timely discharges from the hospital i.e. Provision of intravenous antibiotics therapy.

The role of Crisis Response must be clearly articulated to all partners. This will support the much needed shift in identifying and 'stepping up' patients earlier rather than patients being admitted to acute care with the majority of patients being 'stepped down' into the service.

3.2.5 Medical oversight will be provided to those patients who require medical intervention but predominantly the new service will be Nursing and Therapy led and will include therapy and nursing led discharge.

3.2.6 The service must be led by a credible leader who understands the ethos required to provide an exceptional service and is passionate about the aims of the service.

3.2.7 Each episode of care will be individual but the service must be able to provide access to:

Occupational therapy
Physiotherapy
Social work via partnership working
Registered Nurses
Community Specialist Nurses
Health care assistants and care workers
Access to medical staff as required
Staff with expert knowledge to support people with mental health needs, dementia and people with learning disabilities
Access to other disciplines, including the integrated community equipment service and housing services
Generic Workers who can provide both therapy and nursing support
Pharmacists

3.2.8 Patients will be reviewed regularly to ensure they are receiving the right care and support in the right setting. A tracker will be developed to demonstrate patient dependency at a glance. The Barthell Dependency Score will be used to demonstrate the effectiveness of the intervention whilst tracking a patient through the episode of care.

3.2.9 There is an expectation of commissioners that the Medworxx Tool will initially be rolled out across the 24 hour bed base and then across the virtual bed base in patients homes. This will assist the best utilisation of resource across the system.

Shared Assessment Frameworks and Personalised Care Planning

3.2.10 The goals of each patient will include mobility, self-care, continence and activities of daily living such as food preparation as well as resumption of hobbies and social activities. A loneliness assessment tool i.e. UCLA Loneliness Scale must be used to identify patients who are or are at risk of social isolation and loneliness.

Shared assessment frameworks across health and social care will lead to a personalised care plan for each patient, where the patient and their carers are key participants in any decisions made.

The assessment will consist of a Comprehensive Geriatric Assessment, a recognised falls assessment and a recognised frailty assessment for those people over 65 years of age. These assessments will be reviewed as the episode of care progresses.

The focus will be on active treatment and therapeutic intervention detailed through the personalised care plan. The care plan must be outcome based and agreed by and with the individual patient and/or their primary carer.

The care plan will be written in a language understood by the individual and/or their primary carer.

Home and bed based support

3.2.11 The balance of home/bed based support will be based on the presenting needs of the patient. The use of bed based services will be for those people who initially need a significant level of observation; support and high frequency of clinical oversight i.e. care not available through a home based package.

The type of bed-base service each patient is placed into will be indicated by their needs which are identified at the point of assessment whether that is from Secondary Care or the patient's home. These can be either a bed base service within the Independent sector (i.e. Care Home) or within a non-acute setting in a hospital.

The service will include a mixture of residential and 24-hour nursing beds with access to medical support as required, spread across the locality with beds available to support people with cognitive challenges needing expert support and support from the Memory Assessment and support service.

The provision of 24 hour bed based services will be provided in an environment that meets CQC standards all of which should be able to care for people with dementia/memory problems where intermediate care intervention has been deemed as appropriate.

Episodes of care and support will be delivered either at the home of the patient or in a bed based service. There will be patients whose needs could be better met within their own home environment working with existing care and support infrastructures such as people with a learning disability or dementia. It is expected that the provider; working jointly with the referring agency, will deploy interventions within the most conducive environment for the patient.

3.2.12 Therapy input regardless of location will be delivered to anyone receiving time limited re-enablement support at home and short term 24 hour residential care.
Short term intensive Nursing & Therapy support will be delivered either in a patient's own home or as a patient in an NHS in-patient facility.

Single point of access

3.2.12 Central to the service will be RightCare Barnsley. RightCare Barnsley will be the single point of access for the service during the hours of 8am and 8pm 7 days a week including bank holidays.

RightCare Barnsley will be the single point of access for the 24 hour bed base for recuperation and rehabilitation and will place patients into these beds according to the needs of the patient at that time. RightCare Barnsley will monitor and report on the 24 hour bed base activity which will include length of stay.

Outside of these hours robust contact arrangements via a single number to the service including the Crisis Response element must be made with Barnsley Hospital NHS Foundation Trust (BHNFT) – Emergency Department (ED), Clinical Decision Unit (CDU), Ambulatory Care Assessment Centre (AMAC) and the wards, Yorkshire Ambulance Services (YAS) – Emergency Care Practitioners (ECP's), Out of Hours (OOH's) and IHEART Barnsley.

Rehabilitation and recuperation

3.2.13 When choosing the service a patient requires the following grid has been designed to ensure that the patient is placed in the right place to meet their needs the first time.

	Carer Respite/Place of Safety	**Recuperation**	**Rehabilitation**
Remaining in own home	NA	Independent Living at Home (ILAH)	Intermediate Care Team & possibly ILAH
Requiring 24 hours Care	Social care via Customer Access Team (CAT)	Recuperation beds	Designated Care Homes Only
Requiring Nursing Care	Emergency Placement	NA	NHS type Community Hospital facility

When the patients' needs change where ever possible these are met by wraparound care rather than moving the patient.

4. Population covered

4.1 The service will be for adult patients who are registered or temporarily registered with a practice that is part of NHS Barnsley CCG. The provider must ensure that the service is equitably provided across Barnsley, in response to need, particularly in relation to the allocation of resources to ensure that patients have equal access to services which are comparable in terms of quality and

responsiveness.

Boundaries

4.2 This service is commissioned on a Barnsley registered population basis in line with "Who Pays? Determining responsibility for payments to providers" guidance published 12th August 2013. The provider has full responsibility for the delivery of this service to all Barnsley registered patients in line with General Condition 12 of the NHS standard contract. If a patient is resident outside of the Barnsley footprint but registered with a Barnsley GP, it is the responsibility of the provider to ensure services are delivered in line with this specification to that patient. However, in areas where mutually beneficial agreements can be put in place with providers that cover neighboring CCG's that are not detrimental to the patients care or safety permitted sub-contracts will be considered by the CCG in line with General Condition 12.

5.0 Acceptance and exclusion criteria

5.1 People should meet all of the criteria set out below for referral to the single point of access:

a) A resident of BMBC or registered with BCCG
b) Over the age of 18
c) Experiencing an episode of illness or exacerbation of a pre-existing condition, or life limiting long-term condition or recovery from surgery or other procedure
d) Not requiring a level of medical input only available in an Acute Hospital agreed by the MDT discharge planning process
e) Not requiring technological input only available in an Acute Hospital agreed by the MDT discharge planning process
f) Not requiring Out-of-Hours diagnostics
g) Not requiring access to specialist rehabilitation defined in the current specialist services commissioning definitions
h) Requires this service rather than discharge into an agreed pathway *e.g.* neurology or the stroke service
i) Is likely to require more than one health/social care discipline to be involved.
j) A reasonable expectation of recovery including time in a bed based component if required
k) People can be supported, even if they are not nutritionally stable. People should be able to consent and comply with interventions. Where consent is an issue, as in all services a mental capacity assessment must be undertaken and a best interest meeting held if necessary, the outcome integrated into the referral and care planning process.

5.2 Parity of Esteem

a) People with dementia will not be excluded from the service but this may need to be delivered as part of a longer-term support package co-ordinated by the expert dementia service
b) People with a learning disability/mental health need or other diagnosis/vulnerability will not be excluded if they meet the criteria for the service as alternative to an admission to

hospital or speed up discharge from hospital. The service will demonstrate it can make the reasonable adjustment required

c) People whose primary need is end of life care should be supported through end of life care services. However the service will not exclude people if they are experiencing an episode of illness or exacerbation of a pre-existing condition
d) People living in all forms of housing and support accommodation should have access to the service
e) People who have on-going housing needs including people who are homeless or at risk of being homeless should have access to the service

5.3 Sub-contractors

Where an element of the service is provided by an independent or voluntary sector provider; as agreed within the main contract, the provider must ensure that the sub-contracted provider meets the 'approved provider list or similar criteria' as identified by BCCG.
The provider shall inform NHS Barnsley CCG of any intention to sub-contract part or all of the service specified.

6. Applicable Service Standards

6.1 Applicable national standards (e.g. NICE) Must comply with NICE standards due 2017

The National Institute for Health and Clinical Excellence (NICE) have produced a number of guidelines on rehabilitation pathways for people. The Intermediate Care service should understand these guidelines, but recognise that the pathway for different specific condition- based needs will extend beyond the scope of this episode of care.

7. Applicable quality requirements and CQUIN goals

7.1 Applicable Quality Requirements (See Schedule 4A-C)

7.2 Applicable CQUIN goals (See Schedule 4D) TO BE AGREED IF APPLICABLE BY ALLIANCE MANAGEMENT TEAM

8. Location of Provider Premises

The Provider's Premises are located at:

The provision of 24 hour home based support will be led by the most appropriate health or social care practitioner and will meet CQC standards for community and/or domiciliary care provision. Delivery is not necessarily dependent on location of person, where in patient services are provided they meet CQC standards and are conducive to rehab plus dementia friendly.