



Joint Strategic Commissioning Board (JSCB)

Date:	Thursday, 25 July 2024
Time:	12.00 p.m. or on the rise of Wirral Place Based Partnership Board, whichever is the later
Venue:	Committee Room 1 - Wallasey Town Hall

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AGENDA

1. ELECTION OF CHAIR
2. APOLOGIES FOR ABSENCE
3. DECLARATIONS OF INTEREST
4. PHASE 2 INTERMEDIATE CARE REVIEW (Pages 1 - 20)

The appendix to this report may not be suitable to view for people with disabilities, users of assistive technology or mobile phone devices. Please contact lorna.quigley@cheshireandmerseyside.nhs.uk if you would like this document in an accessible format.

Terms of Reference



Joint Strategic Commissioning Board

25th July 2024

REPORT TITLE:	PHASE 2 INTERMEDIATE CARE REVIEW
REPORT OF:	SAYYED OSMAN, DIRECTOR OF ADULTS, HEALTH AND STRATEGIC COMMISSIONING AND SIMON BANKS, PLACE DIRECTOR (WIRRAL) NHS CHESHIRE AND MERSEYSIDE

REPORT SUMMARY

This report seeks agreement in from the Joint Strategic Commissioning Board to progress to phase 2 of the proposed commissioning intentions for Clatterbridge Intermediate Care Centre (CICC) which will be procured via NHS Cheshire and Merseyside

The report sets out the progress to date following the agreements made at the Wirral Place Partnership Board meeting of February 2024 and the requirement to recommission the service based on procurement advice in line with the Provider Selection regime.

The proposed actions affect people from all wards within the borough and this is a key decision.

RECOMMENDATION/S

The Joint Strategic Commissioning Board is recommended to:

1. endorse that a procurement exercise be carried out by NHS Cheshire and Merseyside Integrated Commissioning Board by way of a competitive process in accordance with the Provider Selection Regime for a contract for the provision of intermediate care services. The contractual terms will be agreed by NHS Cheshire and Merseyside and in accordance with the specification set out on in this report.

2. note the extension with the current provider Wirral Community Health and Care Trust until 1st September 2025.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

- 1.1 To support NHS Cheshire and Merseyside to implement commissioning intentions for the Clatterbridge Intermediate Care Centre as outlined within the report.

2.0 OTHER OPTIONS CONSIDERED

- 2.1 Other options have been considered in line with the provider selection regime, these included:
- Direct award A- this is act of awarding the contract to the current contract holder as it is deemed that they are the only provider that can deliver the health care service. This option has been discounted as there is more than one service that could deliver the service.
 - Direct Award B- this option allows multiple providers to enter the market. This does not apply as it is not the intended to be open choice of provider for this service.
 - Direct Award C is applied when the proposed contracting arrangements are not changing considerably. As the ultimate contract award is likely to breach the considerable change threshold for this process this too has been discounted. Most Suitable provider. This could be used but could be subject to challenge.

3.0 BACKGROUND INFORMATION

- 3.1 Phase 1 of the review was completed in January 2024, and has travelled through the governance routes including Wirral Place Partnership Board (March 2024) and NHS Cheshire and Merseyside Finance, Investment and Resource Committee.
- 3.2 The recommendations and approvals made within these fora Included:
- The extension with the current provider Wirral Community Health and Care Trust until 1st September 2025.
 - During this extension period a change to the current service specification to improve service delivery in relation to medical cover into CICC. The contract for medical cover to the CICC beds is currently held by Civic Medical Centre under a sub contract and will expire on 31st September 2024 whereupon the medical cover provided pursuant to this contract cover will move back into the main contract provision in line with the revised service specification. The current provider (Wirral Community Health and care Trust) will therefore be notified, and responsibility for medical cover will therefore sit with the provider from 1st October 2024 until the expiry of the contract on 1st September 2025
 - The pharmaceutical contract expired in March 2024; this service has now been in housed.
 - The development of a new service specification to be implemented September 2025
 - Procurement advice to be sought in line with the provider selection regime.

3.3 Based on phase 1 of the review a new service specification has been drafted (appendix 2) . This has been led by commissioning clinicians. The draft specification will form part of the pre- procurement to allow all interested parties the opportunity to comment upon and amendments to be made pre formal publication.

4.0 FINANCIAL IMPLICATIONS

4.1 The intermediate care beds are jointly commissioned between NHS Cheshire and Merseyside and the Council through the Better Care Fund (BCF). The value of the Better Care Fund for 2024/25 is £62m based on contributions from NHS Cheshire and Merseyside and Wirral Council. The current CICC contract for 71 beds has a value of £6.5 plus a further £0.2m for medical cover. This is included in the BCF plan for 2024/25. A further update on the financial implications will be given to the Joint Strategic Commissioning Board once the outcome of the procurement process is known.

5.0 LEGAL IMPLICATIONS

5.1 The Provider Selection Regime (PSR) was introduced by regulations made under the Health and Care Act 2022 and is a set of rules for procuring health care services by (amongst others) Integrated care boards, NHS trusts and NHS foundation trusts and Local authorities

5.2 The PSR has introduced three alternative selection processes which are:

- **Direct award processes (A, B, and C).** These involve awarding contracts to providers when there is limited or no reason to seek to change from the existing provider; or to assess providers against one another, because:
 - the existing provider is the only provider that can deliver the health care services (direct award process A);
 - patients have a choice of providers and the number of providers is not restricted by the relevant authority (direct award process B); or
 - the existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably (direct award process C);
- **Most suitable provider process.** This involves awarding a contract to providers without running a competitive process, because the relevant authority can identify the most suitable provider.
- **Competitive process.** This involves running a competitive process to award a contract.

5.3 The recommendations within this report involve endorsing a competitive process for the tendering exercise.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 The Transfer of Undertakings (Protection of Employment) Regulations 2006 will be applicable on cessation of a contract and the services provided under that contract passing from one provider to another.

7.0 RELEVANT RISKS

- 7.1 It is necessary to recommission the services highlighted to comply with the Provider Selection Regime. With the decision to procure the beds, risk of challenge to NHS Cheshire and Merseyside's decision making is mitigated as all interested parties can bid to provide the CICC services.
- 7.2 Any tender process it would need to begin in September 2024. A potential timeline is attached as Appendix 1. There will be a procurement cost to NHS Cheshire and Merseyside, which has been considered as part of the decision making.

8.0 ENGAGEMENT/CONSULTATION

- 8.1 As part of the procurement process, a market engagement event will be held to both gauge the interest of the market, receive feedback on the draft service specification and to inform interested providers of the detail of the service to be commissioned.

9.0 EQUALITY IMPLICATIONS

- 9.1 At the commencement of the recommission an Equality Impact Assessment (EIA) will be undertaken to ensure that equality impacts are identified, and actions are taken to mitigate any negative impacts. Equality implications will be part of the re-commissioning process and we expect any partner agency to be able to demonstrate compliance throughout the contract.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

- 10.1 Awarding of the contract will be assessed against social value targets and NHS Cheshire and Merseyside's green Plan 2022.

11.0 COMMUNITY WEALTH IMPLICATIONS

- 11.1 The commissioning of this service within Wirral which is available for all ward across the borough will support employment within the economy. This will be assessed as part of the procurement exercise.

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APPENDICES

Appendix 1 Proposed procurement timeline

Appendix 2 Service Specification

BACKGROUND PAPERS

The Provider Selection Regime (PSR) statutory guidance -

<https://www.england.nhs.uk/publication/the-provider-selection-regime-statutory-guidance/>

TERMS OF REFERENCE

This report is being considered by the Joint Strategic Commissioning Board in accordance with its Terms of Reference as follows:

- To ensure effective stewardship of Section 75 pooled monies and address any issues of concern;

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Wirral Based Partnership Board	February 2024

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Procurement Timeline – Draft – to be confirmed
Procurement Route: Local Tender

Activity	Responsibility	Completion Date
Pre Tender Stage		
Establish Procurement Project Team	Procurement Lead	w/c 02/09/24
Pre-Tender Engagement – all providers	Project Team	w/c 08/09/24
Agree Service Budget and Commercial Model	Finance Lead	w/c 16/09/24
Complete Review of Service Delivery and Scope of the Contract	Commissioning Lead	w/c 23/09/24
Issue engagement day letter	Procurement Team	w/c 30/09/24
TUPE - Request Provisional Staff List from Incumbent	Commissioning Lead	w/c 01/10/24
Market Engagement Day / Webinar	Project Team	w/c 21/10/24
Agree Tender Documents, Evaluation Criteria, Commercial Schedule and TUPE Provisional Staff List	Project Team	w/c 11/11/24
PID incl. Service Specification, Contracting Model and Procurement Route to relevant committee for review and approval	Project Team	w/c 02/12/24
Update Service Specification and Tender Pack following feedback from committee approval	Commissioning Lead Procurement Lead	w/c 20/01/25
Tender Stage		
Finalise ITT and Publish Tender	Procurement Lead	w/c 03/02/25
Clarification Questions Deadline	Procurement Lead	w/c 10/03/25
ITT Closes	Procurement Lead	w/c 31/03/25
Initial Evaluation Meeting	Procurement Lead	w/c 07/04/25
Bidder Presentation Day	Procurement Lead	w/c 21/04/25
Final Evaluation Meeting	Procurement Lead	w/c 05/05/25
Draft Recommendation Report for Committee Approval	Project Team	w/c 12/05/25
Committee Approval – Recommendation Report	Procurement Lead	w/c 19/05/25
Issue Intent to Award Notification	Procurement Lead	w/c 02/06/25
Standstill Period	Procurement Lead	w/c 02/06/25
Contract Award	Procurement Lead	w/c 23/06/25
Contract Mobilisation Stage		
Instruct Incumbent to Disclose Final Staff List (TUPE) and Employee Liability Information with the Transferee Organisation	Procurement Lead	w/c 23/06/25
Contract Sign-Off	Contracting Lead	w/c 23/06/25
Mobilisation Period	Commissioning Lead	01/07/25 – 31/08/25
Contract Commences	Commissioning Lead / Provider	01/09/25

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362.+SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	
Service	Discharge to Assess (including community step up) – Bed Based Care
Commissioner Lead	Heather Harrington
Provider Lead	Amanda Pattullo
Period	01/03/2023-30/08/2024
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

NHS England define 'discharge to assess' as for 'people who are clinically optimised and do not require an acute bed but may still require care services provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting at the right time for the person. (<https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf>).

The services provided should be integrated and promote faster recovery from illness, prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. (<https://www.nice.org.uk/guidance/ng74/chapter/recommendations#intermediate-care>).

Evidence shows the impact of deconditioning for people aged 85 years and over who stay in a bed for 10 days or more, whether acute or community, is equivalent to 10 years of ageing in terms of muscle wastage which is non-recoverable. Active interventions and reduced length of stay is essential to avoid this deconditioning.

The Covid-19 pandemic, and associated Hospital Discharge Policy, has placed a focus on the discharge to assess model and the importance of rapid flow through acute and community beds. People that are ready for discharge are classified within one of four pathways as outlined below:

Discharge to assess model – pathways

Pathway 0

50% of people – simple discharge, no formal input from health or social care needed once home.

Pathway 1

45% of people – support to recover at home; able to return home with support from health and/or social care.

Pathway 2

4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.

Pathway 3

1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

This service specification primarily relates to people within pathway 2 however the provider may in rare circumstances accept people on pathway 1 or 3 if appropriate.

Wirral has historically commissioned a high number of discharge to assess beds from across a number of care homes (circa 94 beds). Whilst this approach has supported flow through the hospital, it is acknowledged that Wirral is an outlier with the National average being 23 community beds commissioned per 100,000. In Wirral this would equate to 74 beds for our population size. Length of stay (LOS) has also proved to be a challenge locally with our LOS far exceeding the national position of 3.5 weeks. This has resulted in a high average cost per person compared to the national position. <https://www.nhsbenchmarking.nhs.uk/projects/intermediate-care>. These findings were reinforced by a 2019 'getting it right first time' (GIRFT) review of the discharge to assess service in Wirral.

As part of the Cheshire and Merseyside COVID response, it has been recognised that capacity for rehabilitation and assessment within the community needs to be strengthened. Rehabilitation, assessment, care and support will be delivered within a person's home wherever possible; however, at times bed-based support may be required. This will be necessary for a defined cohort of people, in circumstances where an individual's identified needs cannot be met in their own home.

There are four services that form Wirral's response. These include:

- Home-based intermediate care
- Reablement
- Bed-based intermediate care
- Crisis response

This specification relates to the bed-based service, supporting both discharge to assess and crisis response to enable admission avoidance. The bed-based service will be integrated with the other elements and people will be supported to step up and step down between the services as their health and care needs change.

Using the trusted assessor model, the service will focus on:

- Rehabilitation for individuals to avoid admission or following an acute admission where the individual is ready for discharge but require additional support prior to returning home or longer-term support services being identified.

- Assessment on individuals within a less clinical environment to assess the needs for long term care.
- Optimising independence and enabling a successful return home through the provision of reablement

This service will be clinically led by the Wirral provider collaborative as part of the Integrated Care System (ICS). The aspiration is to deliver safe high quality, therapy led, integrated services from a single base with nursing and medical support to ensure person centric outcomes are delivered.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

Inputs

- ❖ Clinical Leadership
- ❖ Strategic vision and commitment from Wirral provider collaborative
- ❖ Integrated commissioning approach across NHS and Local Authority
- ❖ Cheshire and Merseyside capacity and demand modelling
- ❖ Best practice pathways
- ❖ Professional skills and knowledge

Activities

- ❖ Robust hospital discharge process supported by Integrated Discharge Team
- ❖ Trusted Assessment embedded throughout admission and discharge process
- ❖ Comprehensive out of hospital assessment
- ❖ Multidisciplinary team (MDT) approach including medical support
- ❖ Ward rounds incorporating SAFER principles
- ❖ Application of personalised care planning
- ❖ Care navigation and social prescribing
- ❖ Reablement embedded throughout placement
- ❖ Access to shared records

Outputs

- ❖ Coordinated care for frail / vulnerable adults
- ❖ Individual rehabilitation goals
- ❖ Improved flow through acute and community beds
- ❖ Enhanced independence for people who are supported to return home

Outcomes

- ❖ People have a shorter length of stay in acute and community beds
- ❖ Reduction in deconditioning
- ❖ People and carers are involved in decisions about their future.
- ❖ People are less likely to be admitted/ re admitted to hospital
- ❖ People experience less delays and are supported in an effective and efficient manner
- ❖ Independence is optimised and people are confident that they can be supported in the community
- ❖ More people are supported to return home
- ❖ People are less likely to be transferred into long term care
- ❖ People feel their quality of life is improved

3. Scope

The scope of the service is:

- To deliver rehabilitation for people to avoid admission or following an acute admission where the individual is ready for discharge but requires additional support prior to returning home or longer-term support services being identified.
- To undertake assessment on individuals within a less clinical environment to assess the needs for long term care.
- Optimising independence and enabling a successful return home through the provision of Reablement.

3.1 Aims and objectives of service

The aims of the service are:

- To reduce acute length of stay and admission to hospital by enhancing flow throughout the hospital and community beds
- To reduce deconditioning and loss of confidence associated with spending extended time in an acute setting
- To embed a person-centred approach, focussing on supporting people to return and remain at home safely
- To maximise people's capacity for independent living
- To reduce hospital admissions and re-admissions
- To improve long term health outcomes
- For people to have a positive experience within the service
- To reduce health inequalities across our population
- To reduce avoidable admissions into long term care

3.1.2 Objectives

- Support timely discharge for people as soon as they are deemed ready for discharge
- To adopt the trusted assessment ethos
- Embed personalised care planning throughout pathway
- To work collaboratively with MDT to manage timely discharge for people to return home.
- Enabling assessments for longer term needs to be undertaken in a more appropriate location
- To embed reablement principles throughout the placement and the staff culture

3.2 Service description/care pathway

This service is designed for people who require a period of assessment or rehabilitation following an acute admission or in order to avoid a hospital admission. Every person should be considered for 'home first' pathways prior to this service being accessed.

The service will be operational 24 hours a day, 7 days a week with referrals and admissions being accepted between 8am and 8pm each day. There will be no upper limit to the number of admissions accepted per day, this is based on a risk assessment.

People with an active covid status will not be transferred into the base.

Hospital Discharge Process

The Transfer of Care Hub will be responsible for coordinating the placements of suitable individuals. This will be facilitated using the trusted assessment model. Once the Trusted Assessor (TA) has completed an assessment, the person will be confirmed as needing one of the following support pathways:

- Suitable for home care – “home first”
Person can be safely managed / supported in their own home
- Suitable for residential care
Person can be safely managed/ supported in their residential care placement
- Suitable for D2A bed base**
Person meets admission criteria and has clear functional goals / assessment needs
- Suitable for residential EMI
Person classified as residential level Elderly Medically Infirm and requires either a longer-term placement or a specialist short term placement for a period of further assessment
- Suitable for nursing EMI
Person classified as nursing level Elderly Medically Infirm and requires a longer term placement

All people referred will be effectively case managed by the health and care professionals within the Transfer of Care Hub. A robust handover will be facilitated for all people accessing the D2A service.

The Provider will have a manager or deputy responsible for receiving and reviewing referrals and assessments. Providers to endeavour to respond to referrals within 1 hour.

A minimum of 7 days' supply of medication, dressings and continence products will be supplied by the acute trust thereafter it is the providers' responsibility to manage / provide.

The following documentation will accompany the person to the service:

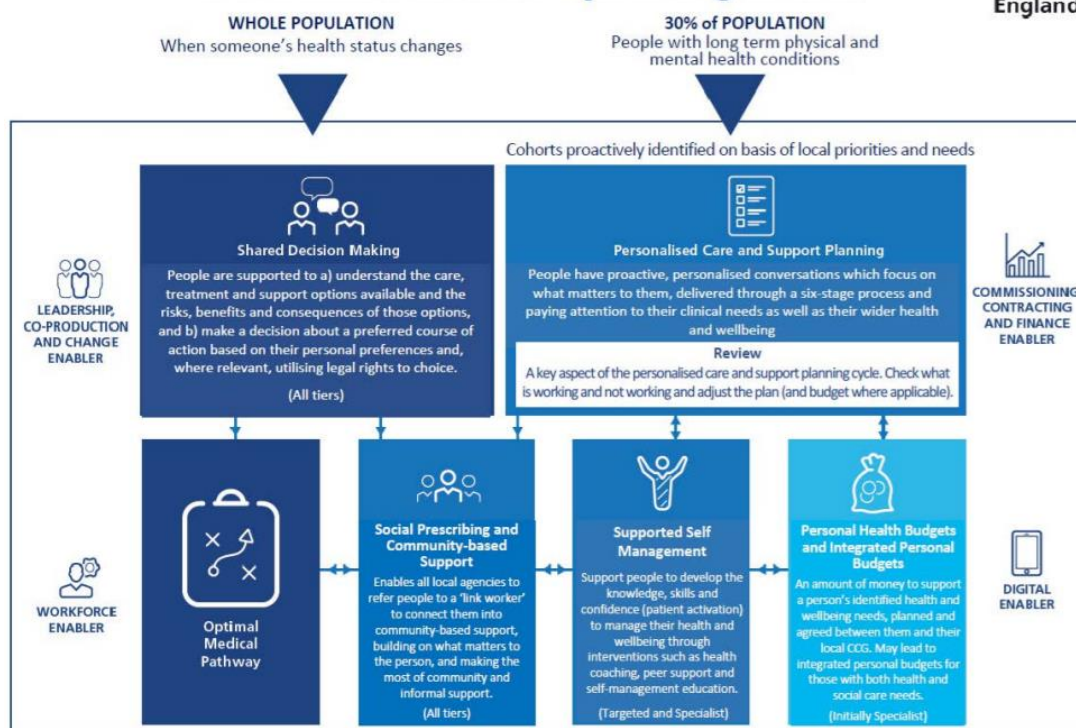
- Hospital discharge letter
- Body Map
- MAR sheet

Admission to facility

Upon admission to the community bed base, all people referred will be allocated a Lead Professional responsible for their care needs. This is likely to be a therapist or Social Worker. The role of the Lead Professional is to be responsible for the overall care of the person while in the facility.

Person-centred care planning will commence immediately, adopting the personalised care operating model as demonstrated below:

Personalised Care Operating Model



MDT

An MDT approach will be adopted to care. The core MDT will include (as a minimum):

- Nurse
- Social Worker
- Physiotherapist
- Occupational Therapist
- GP

The following additional specialists will in reach support when required:

- Individual commissioning nurse
- Third sector organisations including housing corporations

Additional support may be requested from other specialists as required e.g. community geriatrician/ mental health.

The MDT will participate in daily ward and board rounds (7 days a week) as well as twice weekly MDT meetings. Please note, not all members of the MDT will be required at every ward / board round. A weekly Long Length of Stay (LLOS review will be led by the Service Director or Service Lead.

A mini board round is held at the weekends/bank holidays and flow is maintained with proactive discharge planning across 7 days.

The MDT is responsible for:

- Working collaboratively to provide a holistic assessment of people's need for ongoing health and care services; including eligibility to Continuing Health Care (CHC)
- Work with the person to establish a personalised care plan that will support the person during the admission and once they return home or to a longer-term placement. This

will include clear therapy goals and outcomes which will be supported by the MDT.

- Work proactively and effectively as a team to ensure no person stays longer in the D2A bed than required with an average LOS of 3 weeks.
- Maintain oversight of capacity and flow to reduce average length of stay
- Work collaboratively to deliver the SAFER bundle as outlined below

S	Senior Review	In addition to the multi-disciplinary meeting all people referred will have a senior nurse/therapist review before midday (three times per week by a clinician who is able to make management and discharge decisions). Daily reviews will take place as required.
A	All People	All people referred will have an Expected Discharge Date (EDD) set by the MDT assuming ideal recovery and assuming no unnecessary waiting.
F	Flow	Flow of people to commence at the earliest opportunity from admission to D2A.
E	Early Discharge	90% of people will be discharged from D2A before midday
R	Review	A systematic multi-disciplinary team (MDT) review

Within 4 hours of admission, the following should be in place:

- All people referred will have an agreed estimated discharge date (EDD).
- All people referred will have an identified Lead Professional for their care.
- An initial assessment will have been undertaken covering nursing care needs including; Braden or equivalent assessment tool (pressure ulcers), MUST (Malnutrition Universal Screening Tool), falls and manual handling assessment and an assessment of what is important to the person to support the personalised care plan
- A plan of how the service will work to achieve functional goals

Within 24 hours of admission, the following should be in place:

- Therapists will have undertaken initial assessment, developed active therapy plans and commenced therapy interventions for all applicable referred people

Within 48 hours of admission, the following should be in place:

- Social workers will have met with individuals to commence assessment.
- Social worker/ therapist will have scheduled a family meeting to be held within 2 weeks of admission to support determination of longer-term discharge destination
- Consideration of whether a CHC assessment is appropriate and if so, the MDT to ascertain when the person is suitably settled for this to take place
- GP will have provided a holistic assessment
- A personalised care plan led by the person's needs and supported by the MDT should be in place

People may also receive the following as appropriate:

- Structured medication review
- Dementia and cognitive screening

The MDT will be consistently available 7 days a week between 8am and 8pm. Staff will be deployed flexibly and in accordance with meeting the individual person's needs.

All actions taken by the MDT should be recorded and proactively followed up.

Medical Support

The MDT will be supported by a General Practitioner in collaboration with general practice workforce (e.g., advanced nurse practitioners, pharmacists)

GP support will be provided by Civic Medical Centre Monday to Friday 8am to 6:30pm. Outside of these hours, support will be provided by Wirral GP Out of Hours.

All people transferred to this service will be temporarily registered with Civic Medical Centre. The person ceases to be registered as a temporary patient with this practice on discharge from the community bed base and will revert to the care of the GP practice they were registered with prior to their admission.

All Continuing Health Care and Funded Nursing Care assessments will be carried out by the CHC team from Cheshire and Wirral Partnership Trust.

Additional specialist, medical support will in reach to the unit, where possible, as and when required. This will be discussed and agreed with partners on an individual patient basis

Infection Prevention Control (IPC)

The provider will comply with all national IPC standards. The base will adopt cohorting principles across bays to enable units to remain open safely should an outbreak of an infectious disease occur.

Personal Protective Equipment (PPE)

The provider will comply with all national guidance in regard to the appropriate use of PPE and maintain the highest standards of PPE use in a person's contact. The provider will be responsible for supplying and maintaining reasonable levels of PPE.

Equipment

The provider is responsible for supplying essential equipment as specified in the Care Quality Commission regulations.

The base will be kitted out with appropriate equipment to support rehabilitation and reablement goals.

Activity

Bed status, including activity into and out of the base, to be declared to the **Transfer of Care Hub**

Monthly reporting and quality dashboards to be submitted to Wirral Health and Care Commissioning.

Discharge from the base

Once a person achieves the functional goals set when they entered the service/ has completed assessment needs, they will be discharged to their preferred place of care / most appropriate long-term placement. The MDT should continuously evaluate whether the person's needs could be met at home. If they could, discharge should be facilitated immediately.

Following assessment and on discharge from D2A people may require:

- no further input (person to be discharged)
- a combination of ongoing health & social care support, which may include ongoing rehabilitation organised by the MDT
- a package of care organised by the MDT

The lead professional must ensure that all onward referrals are completed and sent prior to a person being discharged. The MDT will also liaise with Community Integrated Response

Team should they need their support.

Issues delaying discharge should be escalated to professional leads/ senior managers within the provider collaborative and to commissioners as required.

The discharge letter to a person's own GP will be sent on day they leave the service.

The provider is responsible for ensuring that there are sufficient medications for the person on discharge and they are discharged with all their belongings and walking aids.

3.3 Population covered

This service will support Wirral residents over age 18 who meet the acceptance criteria outlined below. By exception, out of area patients may be accepted to support system flow.

3.4 Any acceptance and exclusion criteria and thresholds

The acceptance and exclusion criteria are defined below, the list is non exhaustive and suitability to be based on both a needs and risk-based assessment.

Acceptance criteria:

- People stepping up from community to avoid an admission into acute care or stepping down from acute care.
- Adults (aged 18+) who have completed their acute episode of care but are unable to return to their usual place of residence
- Those who have been assessed as having rehabilitation potential which will enable a timely return to the person's ordinary place of residence and own home
- Individuals who require a period of assessment to support longer term health care needs
- Individuals who can and have consented (in line with Mental Capacity Act) to engage in a period of rehabilitation and reablement – this may include people with dementia or a learning disability
- People who require a best interest decision made and family/ next of kin included in decision making if appropriate
- People who are post-surgery who have made a postoperative recovery.
- Non-weight bearing individuals requiring assessment / reablement / rehabilitation e.g., amputees
- People who have been approved by the Trusted Assessor as suitable for D2A care
- People who are experiencing an episode of illness or exacerbation of a pre-existing condition if they are able to engage with the service. This may include people receiving palliative care (but not those deemed to be within the last days/weeks of life)
- People who do not have Covid-19 or are deemed non-infectious as per current IPC guidance

Please note, the above criteria will be inclusive of all suitable individuals (based on a needs/risks-based assessment) including those with:

- Dementia / Learning disabilities
- Autistic spectrum disorders
- Additional nursing needs (e.g., tracheostomy support, self-supported continuous oxygen)
- Housing related needs

Exclusion criteria:

- Individuals whose needs are identified as requiring nursing level EMI provision
- People with Covid 19 positive status (under 14 days or continue to be symptomatic) or any infectious condition which requires the use of isolation facilities or barrier nursing.
- People with sub-acute medical needs
- People requiring 24-hour medical care due to being medically unstable

- People requiring IV fluids
- People under the age of 18 years
- People with complex behaviors that could present risk and safety concerns to themselves and others
- People receiving End of Life Care and within last days of life (eligible for fast track)
- People requiring a specialist rehabilitation pathway e.g., acute ABI/stroke
- People requiring a short-term placement with no rehabilitation or assessment needs
- People who have acute drugs/alcohol withdrawal

The service will not include/exclude groups of people based solely on their condition/ diagnosis, such as dementia, learning disability or housing circumstance, but based on assessed need and risk of the individual patient whilst considering the overall needs and dependency of the existing patients on the unit.

3.5 Interdependence with other services/providers

- Transfer of Care Hub
- Community Integrated Response Team
- Primary Care Clinicians (GP's/Practice Nurses)
- Continuing Healthcare Team
- Dementia nurse
- Wirral University Teaching Hospital
- Wirral Community NHS Foundation Trust
- Cheshire & Wirral Partnership Trust
- Wirral Independence Service (Medequip)
- Third Sector
- Domiciliary care providers
- Housing associations

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

4.3 Applicable local standards

5. Performance Management

The service will be contracted via the NHS standard contract. A quality monitoring schedule will be included with this to ensure that outcomes are achieved.

Outcomes of the Service

The outcomes of the service will include:

- The provider will work collaboratively with partners to support a reduction in the LLOS and No Criteria to Reside (NCR) cohorts within the Hospital (this will be measured based on NCR data however it is acknowledged that CICC is one of many factors impacting NCR activity).
- Readmissions from the base into hospital will be minimised. A specific threshold to

be agreed following a joint clinical audit of re-admissions.

- Average LOS of 3 weeks (to be reported by median and mean)
- Completion of Cheshire and Merseyside Intermediate Care Dataset
- All individuals will have achieved their rehabilitation goals planned for CICC
- Positive experience of, CICC admission and discharge process.

These performance targets should be part of a regular review by all partners

6. Applicable quality requirements and CQUIN goals

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

6.2 Applicable CQUIN goals (See Schedule 4D)

7. Location of Provider Premises

7.1 The Provider's Premises are located at:

8. Individual's Placement

9. Applicable Personalised Care Requirements

9.1 Applicable requirements, by reference to Schedule 2M where appropriate

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Joint Strategic Commissioning Board Sub-Committee

Terms of Reference

A Sub-Committee of three (3) or more members of the Adult Social Care and Public Health Committee, subject to political balance, to sit in common or jointly with representatives of the National Health Service and to exercise delegated authority on behalf of the Council in respect of:

- (a) pooled funding arrangements with the NHS or other governmental bodies;
- (b) the place based health and care arrangements as may be provided for by legislation; and
- (c) such other commissioning, strategic design quality and performance of health and care services across the Borough of Wirral, including the outcomes and quality of those services,

within the terms of reference of the Adult Social Care and Public Health Committee, that the Committee may from time to time determine shall be the responsibility of the Sub-Committee.

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