Invitation to Tender

Rapid Community Service

Contract Reference: 9UWF 9SM76E

RETURN OF INVITATION TO TENDER RESPONSE

The closing date for tender submissions is:

10:00 on 01/06/2015

http://www.the-chest.org.uk

Tenderers must read the “Instructions for Tenderers” attached to the online supplier questionnaire on The Chest.

CONTACT AND QUERIES

If any tenderer wishes to raise any queries which may have a bearing on the offer to be made or have any specific questions regarding this process, please liaise with Wirral Council Corporate Procurement via The Chest at the earliest opportunity, and in any case not later than 12 noon, 3 working days prior to the closing date. Questions raised after this time may not be responded to. Tenderers must ensure anonymity when raising questions.

Tenderers are advised that where such enquiries have been made, and it is appropriate to do so, the Council will distribute to all tenderers a copy of the enquiry and the written reply, with anonymity preserved, via The Chest. It is the tenderers responsibility to ensure that they check for any new information.

PLEASE DO NOT CONTACT OFFICERS VIA ANY OTHER METHOD AS A RESPONSE WILL NOT BE PROVIDED.

Tenderers or bidders are required to indicate those parts of their submission that they regard as commercially sensitive in the event that information requests are received from third parties.

USING THE CHEST

Supplier Guides on how to use The Chest can be found by clicking on the “Help” button at the top right hand side of the screen.

In the event of any TECHNICAL problems using The Chest, please contact:

nwsupport@due-north.com

Telephone: 0845 293 0459
(08:30 - 17:30)
1.1 **Scope**

This contract is primarily for delivery of goods or services to council establishments in Wirral. Wirral is a Metropolitan Borough of Merseyside in the North West of England with a population of approx 300,000 over 60 square miles. Further information about Wirral is available on our website (www.wirral.gov.uk).

1.2 **Wirral Council Strategic Review**

Wirral Council is currently undergoing a strategic review and due to the uncertainty of services required in the future, there is no guarantee as to the level of business under this contract.

1.3 **Contract Duration**

The contract is initially for 5 years starting on 01 September 2015, with the option to extend for up to a further 2 years.
The Wirral Intermediate Care Rapid Community Service has, as its primary function, the prevention of admission to hospital or facilitation of discharge from hospital through a rapid, co-ordinated response and by operating 7 days a week. Lot 1 of this service comprises provision of Intermediate Care and Transitional Care bed provision. This service specification outlines the main aims of this provision, the services to be provided within the contract and the connections to other services in the community.

Providers must take into consideration the underlying principles of the Care Act 2014 in the delivery of
this service. The key principles of the Act include the following:
- Promoting individual wellbeing
- Preventing people’s care and support needs from becoming more serious
- Promoting integration of care and support with health services
- Providing information and advice
- Promoting diversity and quality in provision of services
- Public, private and community sector partners co-operating effectively

KEY SERVICE OUTCOMES

a) Individuals regain their optimum independence and mobility following an episode of ill-health, an injury or an exacerbation of a long-term condition, leading to less dependency on formal services and tailored on-going support at the least intrusive level
b) People feel that their care is personalised and their quality of life is improved
c) People feel that their choice and control are prioritised to meet their individual needs and preferences.
d) People are more confident and able to be supported in a community setting
e) People are protected from avoidable harm and risk whilst in the care of the Rapid Community Service; but supported to take positive risks
f) People assume personal responsibility for their recovery
g) Social value is maximised

1. Purpose

1.1 Aims and objectives

1.1.1 The purpose of the service is to:
- Support timely and planned discharge from hospital and maximise potential for independent living and rapid recovery
- Prevent unnecessary hospital admissions
- Prevent unnecessary admissions to long term residential care
- Provide access to a responsive, personalised service that takes account of the whole range of health and well-being needs including family or friends who provide care and support upon which individuals rely in order to live an independent life
- Facilitate a smooth and seamless return to on-going care arrangements that have been adapted to meet any change in their long term needs

1.1.2 The aims of the service are to:
- Avoid people going to hospital unnecessarily
- Maximise independence
- Prevent people moving to residential care prematurely
- Reduce occupied hospital beds
- Reduce occupied long term care home beds
- Reduce emergency hospital admissions and re-admissions and the use of short term residential/nursing care home placements
- Prepare customers for the next stage in their support journey
1.2 National/local context and evidence base

1.2.1 The evidence base for the Intermediate Service is well developed in a number of key documents:

- Prevention Package for Older People (2009)
- Intermediate Care – Halfway Home (2009)
- A Vision for Adult Social Care (2010)
- Transforming Community Services: Ambition, Action, Achievement – Transforming Rehabilitation Services (2010)
- Think Personal, Act Local (2010)
- The Care Act 2014

1.2.2 Reports from Wirral University Teaching Hospital NHS Foundation Trust have shown that there are significant numbers of patients in hospital at any one time who are considered to be ‘medically fit’ (as determined by the in-patient clinical team) and could be discharged, but they are waiting to be assessed for health or social care in the community before they can leave the hospital, including intermediate care services. A consequence of this is the continued in-patient stays and/or short term residential/nursing care home placements pending the provision of assessment and care planning systems and processes.

2. Scope

2.1 Service Description

2.1.1 The Rapid Community Service provision consists of:

- Up to four Multi-Disciplinary Teams (to be detailed in the separate service specification) which will work across the whole system with effective communication processes to enable consistency of care.

- Community services and the rapid support service which aims to prevent admissions and support people in the most appropriate environment. These services are accessible to GP and include:
  - Reablement services
  - Domiciliary Care
  - 72 hour Rapid Support Service
  - Respite

- Intermediate Care and Transitional Care bed based services to be based in up to four locations in Wirral, to service the four constituency areas of Wallasey, West Wirral, Birkenhead, and South Wirral

2.1.2 Providers can offer a minimum of 20 and a maximum of 60 beds in any one location.

2.1.3 In addition to the weekly sum paid per bed, additional funds are available to the successful provider/s for provision of the physical requirements of the service (4.1.1 – 4.1.5)

The additional funding may be spent in the areas detailed in 4.1.1 – 5.1.5 in the following ways:

- Acquiring a tangible asset
- Repairing an asset in such a way that it extends its useful life
- Upgrading/improvements to an asset
- Restoring or adapting an asset for a new or different use
2.2 Definitions

2.2.1 **ICCT / Integrated Care Coordination Teams** are based in four localities across the Wirral and who provide care planning input into the health and social care management of complex presentations and situations.

2.2.2 **Multi-Disciplinary Team** is an integrated team of health and social care professionals which manages all referrals and co-ordinates the care of individuals using the Rapid Community Service.

2.2.3 **Criteria / streams** is the descriptive process of the service provisions in the Rapid Community Service, recognising the different levels and types of care for individual needs and circumstances.

2.2.4 **Intermediate Care** comprises services which:
- are targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS inpatient care.
- are provided on the basis of a single comprehensive assessment, resulting in a structured, integrated, individual care plan which involves active therapy, treatment or opportunity for recovery.
- have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- are time limited, normally no longer than six weeks and frequently as little as one to two weeks or less.

2.2.5 **Transitional Care** provides a bed based service for those patients who may need further assessment and/or some level of rehabilitation input.

2.2.6 **Reablement** is defined as the use of timely and focussed intensive therapy and care in a person’s own home in order to enable them to remain or return to living independently. This approach focusses on optimising people’s independence with the lowest appropriate level of on-going support and care.

2.3 Criteria for the Rapid Community Service

2.3.1 **Streaming model**

<table>
<thead>
<tr>
<th>Stream/criteria</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Home with NO support</td>
<td></td>
</tr>
<tr>
<td>(home includes nursing/residential setting if this is patient’s home)</td>
<td></td>
</tr>
<tr>
<td>Patient is medically fit and no other issues identified</td>
<td></td>
</tr>
<tr>
<td>1 Home with some support</td>
<td></td>
</tr>
<tr>
<td>Patient is medically fit but requires some level of support to enable discharge and recovery. Patients may require more support at home, such as more intensive care or services available for a longer period depending on need.</td>
<td></td>
</tr>
<tr>
<td>2 IMC Bed Provision</td>
<td></td>
</tr>
<tr>
<td>Individuals have an immediate rehabilitation need/or potential</td>
<td></td>
</tr>
<tr>
<td>3 Transitional Care Bed Provision</td>
<td></td>
</tr>
<tr>
<td>(needing further assessment including EMI, CHC)</td>
<td></td>
</tr>
<tr>
<td>Individuals may require a period of further recuperation or further assessment</td>
<td></td>
</tr>
</tbody>
</table>
2.3.2 The Intermediate Care component of the service provides a short term programme of therapy, help and support either at home or within a care home setting, in order for a patient can regain their independence following a period of ill health. The service is for people who need short term support to enable them to return safely to their own home or remain at home. This may follow a stay in hospital after an illness or an operation, or a home visit from a GP, health or social care professional.

2.3.3 To receive the service people must:
   a) Be over 18 years of age, recognising there is a focus for those post 65 years of age
   b) Require rehabilitation or supported recovery within a community setting
   c) Be able to respond to a programme of care promoting recovery and independence
   d) Have a suitable home environment to return to following the residential intermediate care
   e) Be registered with a Wirral GP
   f) Be aware and consent to the referral for the service provision, recognising a presumption of capacity
   g) Be able to have their health and social care needs met in the community
   h) Be fit to transfer from and deemed ‘medically fit’ if referred from an acute hospital bed. In those situations where the status of a patient is questioned in terms of medical fitness, this would be discussed by the appropriate Team/Service Managers to resolve

2.3.4 The criteria and pathway for the Intermediate Care and Transitional Care beds are detailed below as both a step up from home and step down from hospital service.

2.3.5 This service is available to GPs who believe that more support is required for specific period for either rehabilitation or assessment but a hospital acute bed is not required. The service is also available to NWAS for direct admissions. A 72 hour rapid support service is also provided to minimise hospital admission and maintain independence for patients

2.3.6 Referrals are not made directly to the provider but via the single multi-disciplinary team. As part of the process, consideration must be given to a community based care provision as an alternative to a bed based service. This includes referral to reablement services. IMC services are available for a period of up to six weeks. Included in any referral and subsequent discussion of service provision is the timescale for the return of the individual to their home environment.

2.3.7 The service for both Intermediate Care and Transition Care Beds can be accessed for a maximum period of six weeks (free of charge to the patient). Patients may be placed in a Transition Care bed for up to this period and subsequently moved on to an IMC bed. In these cases, the patient will receive the IMC service free of charge for up to six weeks.

2.3.8 Criteria for Intermediate Care Beds

Customers may access an intermediate care bed:

   a) when they have an immediate rehabilitation need/potential. This may follow a loss of function, accident or other deterioration caused by a health need/episode. Therapy Assessments will need to clearly identify the potential for this and the goals to be achieved.
b) when they can participate cognitively and physically in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.

c) when they are going in for planned elective surgery, where the likely need for rehabilitation has been established.

d) when there is clear evidence that the Individual aspires to return home

e) for up to a maximum of 6 weeks. It is the aim that the customer remains in the service as short as time as both clinically safe and practicable

2.3.9 Criteria for Transitional Care Beds

Customers may access a transitional care bed:

a) for a period of further recuperation before returning home following a health episode, hospital treatment or loss of function

b) for further assessment and planning post hospital discharge or due to a health episode where hospital avoidance/prevention is appropriate e.g. UTI or infection

c) when they are no longer in need of an acute bed but do require the benefit of a period of convalescence or rehab prior to moving home safely

d) when they are no longer in need of an acute bed but further assessment and/or care is required. This will be where the situation cannot be managed at home with support.

Specialist therapy input may or may not be required. As a minimum there is an expectation that people will participate in daily living skills as part of their care, rehabilitation and convalescence as reasonably practicable This includes those patients who:

a) are experiencing dementia with the ability to participate in a programme of therapy

b) may require preparation and support to access the next stage of their support journey

2.4 Exclusion criteria

2.4.1 Exclusion criteria are:

a) Patients aged under 18

b) Patients aged over 18 who are not registered with a Wirral GP or who are not resident in Wirral.

c) Palliative patients without rehab needs

2.4.2 All circumstances will be assessed on an individual basis to ensure that access to appropriate services is determined before being excluded from the service. This is the responsibility and function of the Multi-Disciplinary Team who will ensure that the patient, their family and their GP are informed of decisions and actions.

2.5 Geographic coverage/boundaries

2.5.1 The service will accept referrals for patients registered with all Wirral based GP practices.
### 2.6 Whole system relationships

#### 2.6.1 It is essential to achieve the aims, objectives and the functions of the service that the provider works with all parts and services of the health and social care economy. This is not only on an individual practitioner level but also across teams and sectors.

### 2.7 Interdependencies and other services

#### 2.7.1 The provider will work in conjunction with the following range of agencies and service providers in Social Care and Health:

- Wirral University Teaching Hospital (and satellites)
- Secondary Care
- GPs
- ICCTs
- Wirral Department of Adult Social Services
- NHS Wirral Clinical Commissioning Group
- Other Community services
- Mental Health and Learning Disability services
- Voluntary, Community and Faith sector organisations
- Other services as deemed appropriate and when required

### 2.8 Relevant networks and screening programmes

#### 2.8.1 The provider will link with relevant professional networks and the Integrated Care Co-ordination Teams across the four Wirral Constituencies (Birkenhead, Wallasey, Wirral West, & Wirral South) to ensure a case managed approach to patients accepted by the service and their subsequent discharge and aftercare pathways.

### 2.9 Training/education/research activities

#### 2.9.1 The Provider will be responsible to ensure whether directly employed staff, or staff provided through a collaborative working model, have appropriate professional registration and maintain the required standards through on-going professional development. The provider will also be expected to participate in any research and evaluation activities in relation to the service.

### 3. Service Delivery

#### 3.1 Service model

#### 3.1.1 The Rapid Community Service will:

- Support timely and planned discharge from hospital and maximise potential for independent living
- Provide a bed-based service for people over the age of 18
- Provide Intermediate Care (see 2.2.4)
- Provide Transitional Care (see 2.2.5)
- Provide equipment for people with bariatric needs (at least one bed)
f) Provide general support to those residents with Dementia and EMI residents who are able to participate in a programme of therapy

g) Provide a base for the multidisciplinary team which facilitates the Rapid Community Service

h) Be a member of the Multi-Disciplinary Team, fully involved in each stage of the process, including admission, review and discharge

i) Facilitate initial assessment, care planning and on-going review, together with appropriate therapeutic interventions (to be monitored by the Single MDT).

j) Provide access to appropriate advice, support and care to enable faster recovery from Illness.

k) Facilitate appropriate packages of care which:

  i. Ensure the safety, dignity and privacy of people using the service
  ii. Enable the delivery of care closer to home to avoid the need for placement elsewhere through enhanced and comprehensive intermediate care services.
  iii. Maximise independence and optimise mobility to reduce continuing dependency on care and support services
  iv. Reduce the risk of an avoidable acute admission to hospital
  v. Promote early supported safe discharge from hospital of individuals to their own home or into an intermediate care bed
  vi. Prevent an avoidable admission to long term care, which will assume access to GP/Nurse cover to support patients medically and access to services as required, especially where person is admitted from community.

l) Provide delegated care and support in accordance with professional guidelines (single MDT to retain accountability).

m) Respond to referrals from a range of sources (see 3.5) and co-ordinate the care of the individual, as part of the Multidisciplinary Team, be it via admissions prevention (step up) or facilitate an appropriate discharge from hospital (step down)

n) Work with local health professionals (including GP practices) to ensure the medical needs of people using the service are met

o) Provide support for on-going outpatient appointment and external appointments as required by the customer such as diagnostic testing and appointments in clinics

p) Support people using the service to achieve personal goals and achieve as high a level of independence as possible for their own particular circumstances.

q) Ensure a rehabilitation focus to maximise each customers potential for independence, with appropriate support to regain an optimal level of functional independence and encouraging self-care wherever possible.

r) Form part of a seamless continuum of services linking health promotion, preventative services, primary care, community health services, social care, and support for carers and acute hospital care.

s) Contribute to the development of a unified assessment process for and delivery of the Rapid Community Service in Wirral. This will be achieved via the Multi-Disciplinary Team through a one assessment process, shared criteria and co-ordinated, working practices and procedures.

t) Ensure a person centred approach, appreciating the experiences of individuals and their needs
u) Encourage relatives and carers to take an active role in supporting the recovery/rehabilitation/reablement of the customer

v) Facilitate engagement of the resident (at an appropriate level in relation to their need and ability) in day to day activities, including self-care, to ensure independence (this is for both intermediate care and transitional care customers)

w) Provide clear accessible information about what the Rapid Community Service is, how it works and how to make contact

x) Work collaboratively, as part of the Multidisciplinary Team, in planning for the discharge for the patient at the point of admission to the home, identifying any outstanding issues which may impact on discharge (e.g. housing) and communicating with other members of the MDT (e.g. therapists), the customer and carers to ensure all parties are clear of plans and proposed outcomes

y) Be provided in line with the appropriate CQC registration.

z) As part of the MDT, set realistic discharge target dates

3.2 Care Pathways

3.2.1 The high level pathway is described at 3.6.9.

3.3 Location(s) of service delivery

3.3.1 The service is based at up to four identified locations on the Wirral in line with demographic features of local communities and commissioning intentions of Wirral CCG and Wirral Council.

3.3.2 The assessing and coordinating Multi-Disciplinary Teams will be primarily located in each of the locations described in 3.3.1. with appropriate facilities (see 4.1).

3.4 Days/hours of operation

3.4.1 For the other provision identified, the service(s) will operate 24 hours a day, 7 days a week, and 365 days a year for the Bed Based Services. Domiciliary care services will be provided according to the service specification for such services and will operate between 7.00am until 11.00pm, 7 days a week, and 365 days a year.

3.4.2 The ICCTs and the MDT will offer up to a 7 day, 8-8 service

3.5 Referral Sources

Referrals for the service are managed by the MDT and may be from:

- Wirral GPs
- Acute Hospital Staff – supported by the MDT Co-ordinator
- North West Ambulance Service (under development)
- Integrated Care Co-ordination Teams (ICCTs)
3.6 Referral Process

3.6.1 A referral will be made from the community or the hospital to the MDT for an assessment for one of the following:

- Home based service and response (as detailed in a separate specification)
- A Intermediate Care bed
- A Transitional bed

3.6.2 Referrals will be made to the single Multidisciplinary Team which will

- Assess
- identify a placement and
- Facilitate a whole care package for the customer

3.6.3 The Multidisciplinary Team will provide a single health and social care assessment, which will indicate the level of care required and provide advice and/or a sign posting service to support recovery and promote well-being and independence. The assessment will result in a structured goal–orientated care plan that places the emphasis on supporting the individual to return to their normal functionality, or if this is not possible, to maximise their independence.

3.6.4 The care plan will be developed with the customer and (with their consent), their family/carers. If the customer is being discharged from hospital, the care plan will be developed pre-discharge but quickly reviewed once home, to take account of any environmental factors, by the MDT or appropriate neighbourhood team following planned transfer between teams/services.

3.6.5 The needs of the individual’s carer/family will be considered and they will be signposted to any services from which they might benefit (such as a carer’s assessment) and the MDT will ensure effective care coordination. Providers are seen as a key part of this process, with particular reference to the admission, care and review of the patient in the bed based IMC service

3.6.6 There is no charge for Intermediate, Transitional or Re-ablement services for a period of up to six weeks. If the patient receives these services for longer than six weeks the patient should be made aware from the start that there may be a charge. This will be subject to a full financial assessment in accordance with the Council’s Charging Policy.

3.6.7 The provider will respond to referrals within 1 hour.

3.6.8 The IMC Manager or Professional Lead will consider whether the referral meets the IMC criteria and contact the referrer to discuss, advising on potential alternative strategies and support available if the referral does not meet the criteria. Once the assessment has been conducted and the short and long term needs have been established, the care plan will be updated and the case will be re-discussed at IMC case planning meetings.
3.6.9 Summary of referral pathway and process

Referral from GP / Hospital / other professional

- MDT
  - Referral received, screened and assessed
  - Customer informed of outcome of assessment
  - Referrer informed of outcome
  - Provider informed

Customer admitted to provider’s service

Care plan shared, implemented and reviewed

Customer discharged from service

3.7 Discharge processes

3.7.1 Planned discharge from the service will ensure that the individual receives a co-ordinated seamless transfer of care into any setting or services as required. Discharge planning (including home environmental assessments) will be commenced on admission to the Service to enable on-going support needs to be identified and arrangements put in place to meet them. This will be reviewed and amended as required following multi-disciplinary discussions, supported by appropriate documentation.

3.7.2 Discharge from the service should normally take place within a maximum of 6 weeks of admission or 2 weeks for the Rapid Intervention Service. Only in exceptional circumstances and dependent upon professional/clinical judgement of the Multidisciplinary Team can these timelines be flexed.

4. Service Requirements

4.1 Physical Requirements

4.1.1 Therapeutic

a) Dedicated Treatment room (with emergency call bell) with space for running exercise classes, parallel bars, steps, plinth
b) Suitable stairs for stair practice (Max 9) with rail on both sides
c) Space for kitchen practice and assessments (kettle, microwave, toaster, hob, under counter fridge, cupboards low and high) including space in the kitchen for a table for small group activities.
d) Opportunity for customers to practise what they would do at home by preparing their own breakfast and tea e.g. with support from carers, rather than being served

e) Regular divan bed to practise transfers on/off

f) Regular bath to practise getting in and out of

g) Basic equipment
   - commode (Adjustable height)
   - toilet frames
   - raised toilet seats (2” and 4”)
   - chair raisers (suitable for chairs on site),
   - foot stools
   - perching stools
   - hoist
   - full slings
   - samhall turner / ambiturn
   - maintained / serviced wheelchairs

h) Bariatric equipment (to accommodate at least one person weighing up to 30 stone)
   - bed and mattress
   - hoist
   - full sling
   - chair
   - commode

4.1.2 Customer Comfort

a) Communal facilities with enough space to access each side of the arm chairs to support moving and handling and space for walking aids to safely be positioned in front of patients to enable independent mobility where appropriate.

b) Call bells in customer rooms, lounges and treatment rooms (or mobile solution)

c) Range of chairs & heights e.g. riser recliner, sofa, armchair (15” min) plus some adjustable height chairs

d) Suitable and appropriate beds which meet the needs of a range of customers

4.1.3 Accessibility

a) Wheelchair access to building with changes in interior levels minimised

b) Accessible dining facilities with appropriate furniture

c) Accessible corridors and doorways suitable for walking aids and wheelchairs

d) Lift access to all floors, with space for wheelchair and staff member

e) Accessible bathrooms and toilets with sufficient space for assessment, dual assistance and suitable equipment e.g. toilet frame

4.1.4 Health & Safety

a) A suitable and safe environment which balances the needs of reablement and therapy programmes with the facilities which customers might experience in their own home
b) Appropriate lighting, ventilation, heating

c) Secure and safe equipment storage space

4.1.5 Multidisciplinary Team

a) Office space to accommodate 6 workspaces

b) Suitable, secure and adequate storage for essential documents

c) Access to staff rest room and accessible staff toilet

d) Broadband / WIFI to facilitate mobile working

e) Access to meeting space

4.1.6 Wirral Independence Service

a) Potential to host peripheral storage facility for community equipment

4.2 IM&T

a) Ensure the information governance statement of compliance is in place

b) Ensure all staff are fully aware of, receive regular updates in, and comply with national and local information governance guidelines and regulations, including the Data Protection Act 1998.

c) Retain and manage records electronically as required by the commissioner

4.3 Health & Safety

4.3.1 The provider must comply with local and national infection control and health and safety standards, and must co-operate fully in local and national audits in this respect.

4.4 Risk Management

4.4.1 Provider to have in place robust systems for the identification, mitigation and management of clinical and non-clinical risk. This will include:

a) Assessment systems in place for environmental hazards. System in place for disaster recovery, contingency and business continuity plans.

b) System in place for a Major Incident Plan.

c) Any significant event or near-miss should be formally recorded and reported to the commissioner within 2 working days; the provider must co-operate fully with any investigative work undertaken as part of significant event review.

4.4.2 The Provider must ensure their staff are fully aware of current Wirral Safeguarding policy and procedure.

4.5 Staff

4.5.1 The provider should ensure that all staff possess appropriate qualifications, have access to regular training and supervision to fulfil their role, including moving / handling and use of relevant equipment.

4.6 Promotional work/ communication

4.6.1 As part of the Multidisciplinary Team the provider will ensure that the service will be promoted sufficiently across Wirral regarding its purpose.
4.7 Patient & Carer Information

4.7.1 The provider will ensure that patients and carers receive the most appropriate, evidenced based and updated advice and information.

4.7.2 As part of the Multidisciplinary Team the provider must work collaboratively on the resolution of complaints.

4.7.3 All complaints and compliments must be formally recorded and issued to the commissioner in line with reporting requirements.

4.8 Patient Engagement/ User Involvement

4.8.1 As part of the Multidisciplinary Team the provider must work collaboratively on obtaining customer feedback and assessing satisfaction levels.

4.9 Data Capture and Reporting

4.9.1 The provider must capture and record the following in relation to each patient encounter:

- Agreed Activity and Monitoring reports demonstrating successful outcomes in line with organisational requirements, including Better Care Fund targets.

4.9.2 The provider must co-operate with all reasonable requests for data capture, reporting and audit in line with commissioner requirements.

<table>
<thead>
<tr>
<th>Service Indicators</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of residents returned home in two weeks</td>
<td>TBA</td>
</tr>
<tr>
<td>% of residents returned home in four weeks</td>
<td>TBA</td>
</tr>
<tr>
<td>% of residents returned home in six weeks</td>
<td>TBA</td>
</tr>
<tr>
<td>% of residents admitted to hospital from IMC who referred by GP/Primary Care</td>
<td>TBA</td>
</tr>
<tr>
<td>% of residents re-admitted to hospital from IMC who discharged from hospital</td>
<td>TBA</td>
</tr>
</tbody>
</table>

- Targets to be agreed with the commissioner following contract award
- Indicators will be reviewed within the lifetime of the contract
### 5. Quality Requirements

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Indicator</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving people’s experience of integrated care (patient/resident and carer feedback)</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Total number of referrals for intermediate care beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Total number of referrals for transitional care beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Number of admissions to IMC and transitional beds from GPs (Primary Care)</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Number of admissions to IMC and transitional beds from the hospital</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Number of customers with bariatric needs accessing IMC or transitional beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Average length of stay per for Intermediate Care beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Average length of stay per for Transitional Care beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Number of stays EXCEEDING six weeks for Intermediate Care beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Number of stays EXCEEDING six weeks for Transitional Care beds</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Numbers admitted to residential home from IMC</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Numbers discharged home from IMC with support</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Numbers discharged home from IMC without support</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
<tr>
<td>Numbers admitted to a nursing home</td>
<td>TBA</td>
<td>TBA</td>
<td>Monthly report to commissioner</td>
<td>Action plan agreed with Commissioner</td>
</tr>
</tbody>
</table>

- Indicators & thresholds to be agreed with the commissioner following contract award
Appendix One

Capacity and Deprivation of Liberty Safeguards

Providers of nursing bed services in addition of providing care for those residents with a mental illness, will also be mindful of the specific legal issues which may arises

It is good practice to provide specific details in order to identify those patients suitable for EMI care beds.

There is also a lawful requirement to undertake a capacity assessment and make a best interest decision where a person is deemed unable to consent to the provision of this service.

The details include the following:

- Details of the dementia symptoms of the patient and treatment
- Capacity and ability to consent to the placement – including evidence of the best interest decision making processes where the person does not have capacity
- The patient’s capacity will need to be assessed by the either the IDT or the Rapid Response MDT prior to any placement being arranged. A clear record should be made where the person lacks capacity, the placement is made in their best interests. The assessment of capacity and the best interest decision must be compliant with the guidance in the MCA Code of Practice.
- A copy of the capacity assessment and best interest decision should be given to the care home. This will allow the care home to ensure the best interest decision is complied with and offers colleagues protection under sections 5 & 6 MCA. The home will be notified and they would request authorisation.
- Information regarding any assessment under taken by Wirral Memory Assessment Service, including treatment options and plans or an agreement for referral to Wirral Memory Assessment service/diagnosis or request for CPN assessment
- On occasions, capacity may need to be assessed whilst the patient is in the EMI home. If this occurs, the MDT will be informed and the professionals within the MDT will action this.
- If the home believes that the patient’s liberty is being deprived, the managing authority for people funded by Wirral or self-funding in Wirral must make a referral via CADT for an assessment for Deprivation of Liberty.

Providers should be aware of the process for making Urgent and Standard DOLS requests and the requirement for undertaking reassessments
3.1 Evaluation

The award of this Contract will be on the basis of the most economically advantageous tender taking into consideration the following award criteria:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price</td>
<td>20%</td>
</tr>
<tr>
<td>Quality</td>
<td>80%</td>
</tr>
</tbody>
</table>

The price per bed per week is fixed for the duration of the contract at £643 per bed per week; however there is a separate amount available to support the provision of the physical requirements of the specification (4.1.1 – 4.1.5). Please see ‘Pricing Schedule’ for more detail.

The Quality element will consist of method statements.

3.2 Scoring Mechanism

The scoring mechanism for scored questions in this tender will be as per the “Instructions for Tenderers” attached to the Supplier Online Questionnaire.

If tenderers score less than a 3 on 2 or more of the method statements, Wirral Council reserves the right to exclude the tenderer.

Compliance questions - Tenderers are required to confirm their level of compliance with each of the requirements selecting the appropriate box. The Compliance questions will be marked as pass or fail. If you do not “Fully Comply” with any of the requirements, please provide details of why in the “Comments” section on the Online Supplier Questionnaire where the Evaluation Team will consider if your response is acceptable.

3.3 Site Visits and Interviews

Questions relating to all areas in the invitation to tender may be explored. The purpose of your site visit and interview is to clarify and verify the content of your tender.

Duration of site visits to be agreed. Clarification interviews will last no more than 30 minutes. Site visits and interviews will be scored.

- Site visits are scheduled to take place 3rd, 4th, 5th June 2015
- Interviews are scheduled to take place 17th and 18th June 2015

Interviews will be held at: Old Market House, Hamilton Street, Birkenhead, Wirral, CH41 5AL

Directions can be found at: www.wirral- mbc.gov.uk/wec/PEC%20How%20to%20find%20us.pdf
**Section 4 – Online Supplier Questionnaire**

4.1 **Online Supplier Questionnaire**

Tenderers are required to complete the online questionnaire on The Chest and attach any associated documents to the relevant Supplier Online Question. If they are not attached to the relevant question, they may not be considered in the score. Please note, standard information on non contract specific questions may be saved on the Chest for up to 1 year. It is the supplier’s responsibility to ensure that the information is up to date and relevant for any other tender process they may participate in during that period.

It is the tenderers responsibility to ensure that they read the full questions, including description and supplier help on the ONLINE VERSION and any attachments. Responses to questions should be provided online, on The Chest.

Please note any word/character limits. Please ensure that your responses are concise and contain the requested information, even if there are no word limits. Do not include any unnecessary attachments unless specifically asked for as they may not be considered.

Please note that user guides are available on how to view/complete online questions under the “Help” section on The Chest. If you are still unable to view/complete online questions after reading this, please contact Support on:

Email: nwsupport@due-north.com
Telephone: 0845 293 0459 (08:30 - 17:30)

Please note that the information in the online supplier questionnaire will form a critical part of the selection process. Failure to provide responses to compliance questions and scored questions may result in your submission being rejected and therefore not invited to the tender stage.

It is important to note that the tenderers response to these sections will form part of the tender submission, and if accepted, will form part of the contract specification.
Please note that compliance requirements will be put online.

Tenderers are required to complete the compliance table below. This table will form a critical part of the appraisal process.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Non Comply</th>
<th>Part Comply</th>
<th>Fully Comply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The provider must be registered with the Care Quality Commission for the provision of nursing care and fully compliant at contract award. <strong>This is a mandatory requirement.</strong></td>
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</tbody>
</table>
**Method Statements**

Please note that method statements will be put online.

<table>
<thead>
<tr>
<th>MS No.</th>
<th>Weighting %</th>
<th>MS Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30</td>
<td>Provide an outline of how you will deliver the specified service, including location, physical requirements, structure, management, administrative and care staff, on call, and out of hours availability (including arrangements for planned and unplanned absences) <em>(900 words max)</em></td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>Please describe your organisation’s experience of and approach to providing intermediate, transitional, or reablement services. Please provide at least one example of your experience of delivering any. <em>(600 words max)</em></td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>Please describe your organisational values and approach to supervision and clinical governance. <em>(300 words max)</em></td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>Please describe how you respond to individual customer needs and encourage their independence within a therapeutic environment. Please provide examples <em>(300 words max)</em></td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>Please describe your approach to working collaboratively and flexibly with both partners and commissioners. Provide examples, including conflict resolution <em>(300 words max)</em></td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>Please describe your approach to delivery of multiple services in one location and how you maximise available resources. Provide an example of successful delivery <em>(300 words max)</em></td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td>Please tell us how you ensure good communication with customers, families, and partners, including customer experience and feedback. Please give examples <em>(300 words max)</em></td>
</tr>
</tbody>
</table>
Please note that the pricing schedule will be put online.
Tenderers are requested to complete the pricing table below.

**TABLE OF PRICES**

**Bed Price**
The price per bed per week is fixed at £643 for the duration of the contract.

You can bid for a minimum of 20 and a maximum of 60 beds. The final number awarded will be decided by the commissioner.

**Example:** if you bid for 25 beds but are awarded 20, then the total contract value will be 20 x 52 weeks x 5 years x £643 = £3,343,600

**Funds to support the physical requirements of the contract**
In addition to the weekly sum paid per bed, you may bid for additional funds to support provision of the physical requirements of the service (4.1.1 – 4.1.5)

The additional funding may be spent in the areas detailed in 4.1.1 – 5.1.5 of the service specification in the following ways:

- Acquiring a tangible asset
- Repairing an asset in such a way that it extends its useful life
- Upgrading/improvements to an asset
- Restoring or adapting an asset for a new or different use

The amount of additional funding awarded will be based on a maximum of £28 per bed per week. This is purely for calculation / apportionment and is not related to the fixed bed price of £643.

You may competitively tender for up to £28 per bed per week to support development of the physical requirements of the contract; however the total sum will be paid toward the start of the contract rather than on a weekly basis.

**Example:** if you bid for 25 beds, requesting £25 per bed per week to support the physical requirements of the contract, then are awarded 20, you will receive £25 x 20 beds x 52 weeks x 5 years = £130,000

The amount which you submit will be competitively scored as the 'price' element of the evaluation criteria detailed in 3.1

Please use the table below to detail the amount requested and the items in 4.1.1 – 4.1.5 of the specification which it will be used to fund.
For further details on pricing, please refer to our guidance notes below.

- All prices in the tender submission must be quoted in GBP.
- All prices quoted must exclude VAT.
- All prices must include installation costs, consumables e.g. Professional services, management reports and Contract Review Meetings.
- Any other costs must be specified.

All products supplied must remain competitively priced. The Council seeks to maximise opportunities for improved pricing due to technology changes, which will be reviewed during Contract Review Meetings.

Wirral Borough Council will not recognise any charges made by the supplier for the duration of the contract that were not received as part of this quotation, unless they represent additional costs brought about by a change of client needs.
I/We the undersigned, hereby quote to supply the goods / service / products detailed in this tender, at the respective prices quoted. (Prices must not include VAT).

I certify that as far as I know, the information I have supplied is accurate.

I/We agree that this tender shall remain open to be accepted or not by the Council for a period of six months from the closing date for the receipt of tenders.

I/We agree that the Council may discontinue the tendering arrangements at any time before a tender has been accepted.

I/We accept the specification and standard terms and conditions embodied in the request for tender and undertake to be bound by them if my/our tender is accepted by Wirral Borough Council.

I/We certify that I/we have not now or will in the future, canvassed or solicited any member, officer or employee of the council and any other companies in the group of which the council forms part, in connection with this tender and that to the best of our knowledge and belief no person employed by me/us or acting on my/our behalf has done such an act.

I/We understand that the Council is not bound to accept any tender and will not be liable under any circumstances whatsoever for the costs I/we have incurred in preparing the tender.

The tender submitted herewith is a bona fide tender intended to be competitive. We have not fixed or adjusted the amount of the tender by or under or in accordance with any collusive agreement or arrangement with any other person.

<table>
<thead>
<tr>
<th>NAME OF CONTACT:</th>
</tr>
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<tbody>
<tr>
<td>DESIGNATION:</td>
</tr>
<tr>
<td>COMPANY NAME:</td>
</tr>
<tr>
<td>ADDRESS (including postcode)</td>
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<tr>
<td>TELEPHONE:</td>
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<td>FAX:</td>
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<td>EMAIL:</td>
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<tr>
<td>SIGNATURE:</td>
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<tr>
<td>DATE:</td>
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