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.

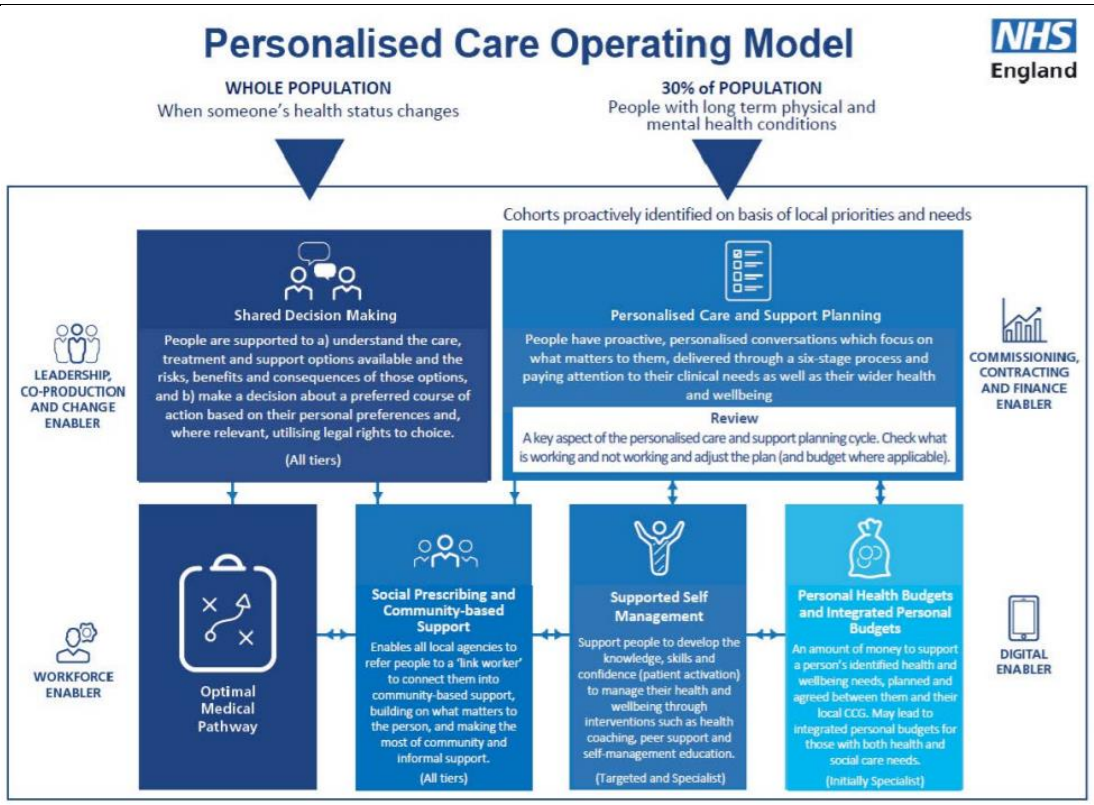
A minimum of 7 days' supply of medication, dressings and continence products will be supplied by the acute trust thereafter it is the providers' responsibility to manage / provide.

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:



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