Southampton City
Clinical Commissioning Group

SOUTHAMPTON
CITY COUNCIL

Cabinet Report: 16th February 2016 **Appendix 3**

Southampton Integrated Commissioning Unit
On behalf of Southampton City Council (SCC) and Southampton City Clinical Commissioning Group (SCCCG)

Service Specification for the Provision of Rehabilitation/Reablement Residential Care Home Beds

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Contents

1 Introduction

Southampton's Integrated Commissioning Unit (ICU) are wishing to commission a number of residential care beds offering short term high quality rehabilitation/reablement care for Southampton residents aged 55 years and over to:-

- Intervene early to avoid unnecessary hospital admission or long term residential or nursing home care.
- Support timely discharge from hospital avoiding unnecessary hospital delays and or excess bed days.
- Maximise long-term independence, choice and quality of life.
- Minimise the level of ongoing support required,
- Minimise the whole-life cost of care

The provision of rehabilitation/reablement care home beds will be to support the work of the Integrated Rehabilitation and Reablement Team.

This service specification describes the values, principles, and service standards that will apply to the provision of rehabilitation/reablement residential care home beds.

It describes what is expected of the Provider, the Commissioner and other partners in allowing for a degree of flexibility and responsiveness in how residentially based rehabilitation/reablement care is provided.

The definition of reablement as used in the De Montfort University evaluation and subsequently adopted by Care Services Efficiency Delivery study team (CSED) is:

> *'Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.'*

Southampton's Integrated Commissioning Unit has used the Care Services Efficiency Delivery (2011) definition to develop its own local definition*:*

'To work alongside a range of professionals, to provide goal-orientated person-centred programmes of care, designed to re-able individuals to become as independent as possible'.

Undertaking reablement in a person's own place of residence is always the preferred option however on occasions the realities of delivering this may create accommodation, staffing or financial challenges that make rehabilitation/reablement in a residential care home a more viable option. In these circumstances the Integrated Rehabilitation and Reablement Service would work with the provider to deliver the rehabilitation/reablement plan returning the individual home as soon as is possible.

1.1 National/local context and evidence base

- Care Act 2014
- NHS Operating Framework
- NHS Outcomes Framework
- Social Care Outcomes Framework
- Public Health Outcomes Framework
- Southampton's Better Care Fund plan
- CCG operating plan and 5 year strategic plan: A Healthy Southampton for All - Bringing together a Healthy and Sustainable System.
- City Council strategy 2014-17.
- City Strategy 2014-25.

- A number of studies have been carried out that have demonstrated the benefits of a Re-abling approach, most notably the De Montfort University (Sep 2000) Leicestershire County Council, External Evaluation of the Home Care Reablement Pilot Project. These note two significant benefits; - that care hours are reduced for a majority of service users; that the reduction is maintained for at least 2 years.
- As a City Southampton:
    - Is above the national average of older people relying on input from social care (5.3% compared to 3.8%)
    - Is above the national rate of permanent admissions of older people to residential and nursing home care
    - Has 86,000 people (32% of our population) with long-term health conditions
    - Is above the national rate for unplanned admissions into hospital for older people
    - Is above the national rate for delayed hospital discharge
- Research evidence demonstrates that reablement improves independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results show that up to 62% of reablement users no longer need a service after 6−12 weeks (compared with 5% of the control group), and that 26% had a reduced requirement for home care hours(compared with 13% of the control group) (SCIE 2011 - http://www.scie.org.uk/publications/briefings/files/briefing36.pdf)
- The "Silver Book" (Quality Care for Older People with Urgent and Emergency Care Needs – 2010) identifies that more vulnerable older people will be living independently thus services need to be developed that respond rapidly to address the needs of older people in the community.

2 Service Objectives

2.1 To provide focussed rehabilitation/reablement in a residential care home environment enabling clients/patients to return home having regained or

achieved an optimal level of independence appropriate to their individual circumstances, their prevailing state of health and their personal aspirations.

2.2 To achieve timely safe discharge and post-discharge support for clients/patients assessed as ready to leave hospital on completion of treatment but who continue to require a period of rehabilitation/reablement in a residential environment post discharge.

2.3 To provide rehabilitation/reablement in a residential care home as a "step up" from the community that avoids unnecessary hospital admission and long term residential or nursing home care.

3 Service Description and Delivery

3.1 Rehabilitation/reablement will be provided to the client/patient in a residential care environment.

3.2 The provider will work in partnership with a range of professionals including the Integrated Rehabilitation and Reablement Service, GPs, social workers and Community Nurses.

3.3 The provider will aim to provide reliable, high quality person-centred residential care, based on continuous improvement and known client expectations.

3.4 The provider home will work in partnership with the Integrated Rehabilitation and Reablement Service to develop and deliver rehabilitation/reablement plans.

3.5 The provider will have contingency plans which include public holidays to ensure service reliability and continuity at all times.

3.6 Care will be structured and all staff will adopt an enabling approach to care giving, encouraging clients to gain maximum independence.

3.7 Staff will be appropriately trained to create and maintain a work atmosphere/culture geared to motivating and supporting clients to gain optimal independence.

3.8 This approach will promote self-confidence, self-esteem and motivation to work towards maximum levels of independence. It will also take full account of the cultural diversity of individual clients and any individual cultural needs.

3.9 Families and carers will be actively involved, where appropriate, in the planning and delivery of targeted support to meet agreed outcomes.

3.10 The Provider will evidence the use of client feedback to modify service provision to promote continuous improvements.

3.11 The Provider will work with the Integrated Rehabilitation and Reablement Service, client, carers, and families, and other professionals to produce detailed individual outcome-focused rehabilitation/reablement plans ensuring that such plans respond and are adjusted to the changing needs and the progress made by clients.

3.12 The provider will work in partnership with the Integrated Rehabilitation and Reablement Service to develop the reablement plan within 48 hours of admission.

3.13 The provider will promote emotional well-being and social inclusion as well as physical recovery.

3.14 The Provider will ensure that clients and Commissioners are regularly informed of any service changes and developments.

3.22 Personal Care tasks are described in this section. This list is not exhaustive.

- Assisting the client to get up or go to bed
- Washing, bathing, hair care, shaving (not with a cut-throat razor), denture and mouth care, hand and fingernail care, foot care (but not toenail cutting or any aspect of foot care which requires a state registered chiropodist)
- Assisting the client with skin care such as moisturising very dry skin
- Dressing and undressing
- Assisting the client with transfers from or to bed / chair / toilet
- Toileting, including necessary cleaning and safe disposal of waste
- Empty or change catheter or stoma bags
- Food or drink preparation
- Eating and drinking, including associated kitchen cleaning and hygiene
- Supporting with PEG, PIG or RIG feeding where necessary, for those clients that require nutritional support.
- Supporting clients at risk of choking by using the National Patient Safety Agency guidelines and Skills for Care guidance regarding assessment and management of choking risk, including working with appropriate local professionals regarding the management of any choking risk
- Ensuring that all risk assessments and support plans are implemented and monitored where necessary and clients are supported where there are any changes in their needs to access health services for ongoing assessment/monitoring of relevant plans
- Assisting with correspondence.
- Assisting with taking medication which has been prescribed to them
- Ensuring that clients that are at risk of self-neglect are identified to the commissioner, and that support plans and risk assessments reflect active decision making as per SCC's Managing Self Neglect Guidance 2013

3.23 Other Support Services

Assisting the client to develop their independence with household tasks that support them remaining at home, such as:

- Cleaning
- Preparing meals
- Making beds and changing linen
- Washing clothes or household linens, including fouled linen, drying, necessary ironing, storage and simple mending
- Disposing of household and personal rubbish

4 Service Eligibility Criteria

4.1 People who live within Southampton City Council boundary.
4.2 People 55 years and over.

4.3 Patients/clients who are assessed by the Integrated Rehabilitation and Reablement Team as having the ability to live in the community with an appropriate level of support following a period of rehabilitation/reablement.

4.4 Patients/clients with complex needs necessitating skilled handling, who will have their potential for improvement compromised without specialist rehabilitation/reablement.
4.5 Patients will not be eligible for a service if they have:

- Severe Dementia
- Palliative Care needs
- Or where an assessment indicates that there is no possibility of Reablement.

5 Management of Referral Process

5.1 The Integrated Rehabilitation and Reablement Service will identify the need for a residential care home based rehabilitation/reablement and will refer to the Care Placement Service to source a rehabilitation/reablement bed.
5.2 The Care Placement Service will source a provider within 24hrs hours of the referral being made. And supply them with a referral form.
5.3 The sourced provider will admit the client/patient within 24 hours of the referral being accepted.

6 Review of Client Service/Care Episodes

6.1 Daily records will be kept and shared with the Integrated Rehabilitation and Reablement Team on a regular basis to report on the needs/progress of the patient/client and compliance with all elements of the rehabilitation/reablement support plan. Commissioners will be able to ask for weekly reports on such feedback to identify progress should this be required.

6.2 Regular feedback will enable the Integrated Rehabilitation and Reablement Team to alter the plan if necessary including expected timeframe for a return home.

6.3 A provider review will take place within two weeks from the commencement of the placement; feedback from staff could bring this review forward if necessary.

6.4 Participation of Provider staff will be required in all reviews in accordance with the standards noted.

6.5 Each patient/client will be offered a satisfaction questionnaire. It is expected that the Provider will actively modify service provision based on the views of the clients providing evidence of this on a quarterly basis.

7 Performance and Quality Monitoring

The Integrated Commissioning Unit will draw on information from a wide variety of sources to identify whether providers are delivering a high quality service to patients/clients and achieving the expected outcomes for patients/clients and the service as a whole. These may include, but are not restricted to, the sources of information outlined in Table 1 below. These become the key monitoring and quality tools to measure provider performance. Where it is identified that the quality of Service does not meet the requirements of the Service Specification, and therefore to the clients, the ICU Quality Team will seek to address this positively, fairly and robustly in partnership with Service Providers.

The Safeguarding and Quality Team will use the Safeguarding in Provider Settings (SIPS) Process (October 2010). The SIPS process will be instigated for any allegation or disclosure which suggests institutional or systemic abuse/neglect in a care setting and/or where doubts exists about the providers capacity to respond adequately to the concerns raised. Institutional abuse is in itself not a form of abuse but more a context in which the abuse is occurring. It usually denotes a poor organisational culture in which poor practice has been allowed to flourish unchecked leading to repeat incidents of neglect, acts of omission and inferior care as well as

other forms of abuse. However, sometimes a single incident may be serious enough to require additional scrutiny under the SIPS process.

Where standards are not being achieved providers will be notified and will be required to develop a service improvement plan to manage any deficits identified. This plan will be agreed by the Quality Team and will become a binding plan. Failure to achieve improvements, following evaluation by the Quality Team, may result in the default process being activated as outlined in the Terms and Conditions of the Framework Agreement, until such time as the provider can evidence improvements.

Quality and Performance Information Source	Timescale	Lead/s
Contract compliance meetings	Quarterly meetings	ICU Provider Relationships Team with the Provider Lead
Provider management information and KPI reports	Quarterly information	ICU Provider Relationships Team with the Provider Lead
Quality Monitoring and Standards Tool	Annually	ICU Quality and Safeguarding Team with Provider Lead
Client questionnaires and surveys evidencing follow up action	Annually	Provider lead and shared/validated by ICU Quality and Safeguarding Team
Care/case management reviews	Annually	SCC/SCCCG Case/Care Management workforce
Quality and Safeguarding Team, collating provider services information and responding to providers where there is a systemic quality and safeguarding issue/s	Ongoing as it arises	ICU Quality and Safeguarding Team
CQC inspection reports and information arising from them. The ICU Quality and Safeguarding Team will meet with CQC regularly to share intelligence.	Annually (minimum)	Providers are expected to alert the ICU Quality and Safeguarding Team to CQC visits within 24 hours of the visit occurring, share reports as they are published and action plans when they are forwarded to The CQC.

7.1 Care Quality Commission

The CQC regulate care services.

Whatever the regulatory framework, it is expected that providers will be fully compliant with The CQC regulations and expectations at all times.

The CQC inspection reports and information arising from them is an essential component of how we monitor quality within services.

The ICU Quality and Safeguarding Team will meet with The CQC on a regular basis to share intelligence regarding the provider's compliance with standards of care and support. If required this may trigger additional reviews of the services and support to clients.

Where The CQC standards outlined within the ICU's Quality Standards and Monitoring Tool, the ICU's additional standards, are not being met, the provider will be expected to develop an action plan to bring them up to compliance standards. This must be made available to the ICU. This action plan will be used, in addition to any other requirements imposed through the Safeguarding and Quality Assurance processes, to ensure compliance and improvement.

Where there is a continuing failure to meet compliance and/or quality assurance standards, the process of default set out in the Framework Agreement will be followed.

7.2 Contract compliance

The contract compliance meetings will include reflection on the previous two quarters, with a bi annual report. A standard agenda template will be used to cover key areas within the contract compliance meetings.

The Commissioner reserves the right to request written records in relation to the activity undertaken in order to satisfy themselves that care has been delivered in accordance with the agreed plans, prior to certifying invoices for payment.

7.3 Provider Management Information and Key Performance Indicators

The Provider will be required to provide a range of management information and Key Performance Indicators on a quarterly basis. Dates for submission will be agreed in advance. Information required consists of:

- The number of referrals:
    - By source (commenting on trends)
    - Waiting times
    - Numbers deselected due to not being suitable for the service and the reasons why.

- The number of clients, detailing:
    - Age
    - Gender
    - Ethnicity
    - Post Code/intake location
    - New clients
    - Repeat clients, and pattern of usage
    - Number of days/duration the client received the service
    - Number of emergency hospital admissions/readmissions (in order to see if the service is being effective/preventative).

- Collection of client outcomes at the end of the service provision, against outcome-focused reablement plans:
    - No ongoing homecare need
    - Increased ongoing homecare need
    - Reduced ongoing homecare need
    - No change to ongoing homecare need
    - To hospital
    - To other setting
    - Use of community services
    - Did not complete the service, for non-completers:
        - refused to continue
        - died
        - returned to hospital
        - declined provision
        - Other (to be listed).

- The number of clients that leave the provision and accept a personal budget, e.g. it will be expected that client's leaving the service will have a broader range of options in place than simply a homecare package

These reports must be provided to the ICU when requested to enable the Council to undertake Quality monitoring and auditing of care provided (via secure email).

Staff data to be collected:

- Turnover
- Retention rates
- Training schedule (planned and achieved)
- Supervisions/appraisals (planned and achieved) including any performance management issues
- Disciplinary information (summary of issue and resultant action)
- Sickness and leave information

- Plans to cover high risk times where capacity issues occur (e.g. holiday periods/disruptions caused by weather). These will link to business continuity plans

7.4 Quality Standards Monitoring Tool (QSMT)

Southampton's QSMT (Appendix 1) has been developed by the Quality and Safeguarding Team based on The Health and Social Care Act 2008, CQC Regulations 2009, CQC Essential Standards, Reach Supported Living Standards and Quality Assurance Framework (Supporting People). The Quality and Safeguarding Team will work with providers undertaking a quality auditing process, based on the QSMT. The QSMT will be up dated and reviewed during the life of the Framework Agreement. Providers are expected to evidence client outcomes against the QSMT.

7.5 Client Questionnaires and Surveys

All providers are required by The Care Quality Commission (CQC) to adhere to Quality and Management Outcome 16 (10e)

This states that a provider must regularly:

- assess and monitor the quality of the service provision; and
- Seek the views of clients (including their experiences of care and treatment).

The Commissioners expect providers to undertake themed surveys related to areas of care that are important to the clients supported, as well as other core areas that require feedback, within our own audit process we will be seeking feedback from clients, carers, experts, other stakeholders as "active participants" (Commissioning principle Four) as this is a key feature to integrate into service commissioning and development.

7.6 Quality and Safeguarding Team, supporting provider services

The team will manage the Safeguarding in Provider Services as per Safeguarding Adults Multi Agency Policy

The ICU has aligned safeguarding and quality assurance oversight for provider services in one area giving more coherence for providers/staff and allowing a smoother transition between safeguarding and ongoing quality monitoring. This will promote safe and effective care. This will address all safeguarding issues using Safeguarding Adults Multi-Agency Policy procedures and Guidance Level 4. This will have the focus on early identification, identify areas for improvement and support providers to implement these.

The commissioners expect providers to follow all appropriate best practice guidance. These will be discussed during contract compliance meetings, and a timetable/plan for their implementation will be agreed, where a partnership approach to implementation is sought.

7.7 Workforce requirements

The Provider shall, as a minimum, comply at all times with the following (and any subsequent amendments thereof), which is not an exhaustive list:

The Care Standards Act 2000	http://www.legislation.gov.uk/ukpga/2000/14/contents
The Care Act 2014	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
The Health and Social Care Act 2012	http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
The Mental Capacity Act 2005	Assessments and Support Plans must take into account the requirements of this legislation. http://www.legislation.gov.uk/ukpga/2005/9/contents
The requirements of the Care Quality Commission	The requirements of the Care Quality Commission http://www.cqc.org.uk/public. The Provider must be registered with the Care Quality Commission to deliver Domiciliary Care. If for any reason CQC registration is suspended or withdrawn, the Commissioner shall remove the Provider from the provider list and, in conjunction with the Client and their Representative, decide if the Client is to continue to receive services from that Provider or be placed with an alternative Provider. The Provider shall promptly inform the Commissioner of the outcomes from a CQC inspection and provide them with a copy of any resulting report.
The Food Safety Act 1990	http://www.legislation.gov.uk/ukpga/1990/16/contents
Skills for Care Adult Social Care Workforce Recruitment and Retention Strategy 2011	The provider can evidence that they have in place robust recruitment and retention policies that meet the Skills for Care Adult Social Care Workforce Recruitment and Retention Strategy (2011). http://www.skillsforcare.org.uk/Document-library/Finding-and-keeping-workers/Recruitment-and-retention-strategy/Recruitmentandretentionstrategy.pdf