Enhanced Intermediate Care / Reablement / End of Life Care Service

Service Specification
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STATEMENT OF COMMON PURPOSES

Introduction:

For some years now Slough Borough Council and Berkshire East PCT have had a pooled budget agreement to deliver an Intermediate care service in Slough. This draft service specification has been developed as part of the renewal of the Section 75 pooled budget agreement.

At present Berkshire East PCT have a work programme of priorities, two of which are preventing crisis and enhancing end of life care, this specification details how the enhanced intermediate care service will be delivered in Slough.

It is important to stress that the present service approach will continue, it is therapy focussed, enabling patients/service users to be as independent as possible. The service also provides end of life care however resources to deliver this are very limited. Adult social care is also in the process of re-configuring their current services. The traditional in-house home care service is becoming a re-ablement service which will use the same therapeutic approach that is currently delivered by the ICT team – this will enable a more seamless way of working with patients/service users as they will be encourage to do things for themselves rather than have things done for them. This approach enables greater independence of people receiving the service. The SBC Reablement service will be fully operation by the 1st of April 2011, once the PCT has confirmed the funding for the Enhanced and End of Life care it is planned that these services too will be full operational by 1st April 2011.

Current performance of the Slough EICT team when compared to other local authorities across the country Slough is in the top quartile. The two main indicators are the number of people remaining in their own homes following 91days after EICT intervention and the other is prevention of delayed discharges, continued performance management will occur through performance meetings that will be held quarterly with the PCT, Lead GP, BECS and SBC.

This service specification is written on the assumption that the PCT will shortly be confirming their committed investment into the enhanced element of ICT (2 hour 24/7 response) and the end of life care. This has now been agreed.
ENHANCED INTERMEDIATE CARE SERVICE

Definition of Enhanced Intermediate and Reablement

A. Enhanced Intermediate Care (EIC) will be targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care;

B. Rapid Response Reablement will respond to referrals and visit people within two hours of the referral. Support will also be provided through the NHS to patients in crisis through the provision of short-term, clinical care, for up to 72 hours at home, with ongoing assessment and, where needed, referral for longer term treatment or community support. This will require a close working relationship between Slough Borough Council and the Berkshire Health Community Service.

C. EIC will be provided on the basis of comprehensive assessment, resulting in a structured individual treatment/care plan that could involve therapy, treatment, the provision of short term equipment and/or opportunity for recovery;

D. EIC will have a planned outcome of maximising independence and typically enabling people to resume living at home independently wherever possible;

E. EIC will be time limited, normally no longer than six weeks and frequently as little as one or two weeks or less

F. Involve cross-professional working, with single assessment framework, single professional records and shared protocols.

G. EIC will be provided free for the first six weeks, thereafter continuing services will be subject to the Council’s eligibility criteria for services and a financial assessment where applicable.

Location of the Enhanced Intermediate Care and Reablement Services (including End of Life Service)

The Team is located at the Intermediate Care Unit- The Pines, Forest Close, Wexham, Slough SL2 4HF.
Tel: 01753 475111

Oak House accommodates the Intermediate Care Unit (Highway Unit) which has nine intermediate care beds.
1. **Aims and Objectives (outcomes) of the service**

The services ultimate objective is to promote and maximise independence by enabling people to continue to live at home. The team is multi-disciplinary and includes Occupational Therapists, Physiotherapist, Reablement Assistants and access to a Community Psychiatric Nurse and Nurse Liaison.

The team will promote independence by providing:

- Rehabilitation through outcome based treatment plans to aid Independent Living skills,
- Access to the provision of equipment and/or telecare equipment.
- Access to rapid response reablement to aid recovery.
- Recuperation and recovery within the Highway Unit.

Enhanced Intermediate Care will meet the following objectives / outcomes:

- Prevent unnecessary prolonged hospital stays and facilitate early discharge, including those patients who have suffered stroke.
- To prevent unnecessary or inappropriate hospital admissions, provide a comprehensive assessment of need.
- To reduce the number of premature admissions into long term care and inappropriate delayed transfers of care.
- To reduce the number of elderly fallers, this will include, where appropriate, responding to falls.
- To provide early treatment plans for people who have elective surgery.
- To provide end of life care to people who wish to end their lives at home.
- Enhanced Intermediate Care is time limited, no longer than six weeks (an outcomes based treatment programme and services may be for less than six weeks).

The service will provide outcome based treatment programmes and services to all adults over the age of 18 who meet the criteria for Enhanced Intermediate Care (including EoLC) Services and Reablement.

2. **Eligibility Criteria**

In order to receive a service, the person referred to the team will:

- Be a registered service user/patient of a Slough GP.
- Be 18 years of age or over.
- If in hospital, be medically fit for hospital discharge.
- If a person living independently has failing health and could be prevented from going into hospital:
• An acute episode of confusion caused by a urinary tract infection
• A person who has experienced a number of falls.
• A person who has suffered a stroke.
• A person who is experiencing a sudden level of reduced mobility.
• A person who is recovering from an acute episode and requires immediate care at home to prevent a hospital admission.
• An acute episode linked to a long term condition.

3. **Scope of the Enhanced Intermediate Care Service**

• To assess and treat people in their own homes this would include Residential Care, Extra Care Housing & Day Care Services.

• To assess and treat people in an Enhanced Intermediate Care bed.

**Residential and sheltered housing beds.**

Currently there are 9 Enhanced Intermediate Care beds in Oak House Residential Care Home (Highway Unit)

**Rapid Response Reablement**

The Enhanced Intermediate Care Team is supported by the Rapid Response Re-ablement Service to provide social care followed by an outcomes focused Reablement programme for people who are referred by the hospital discharge care co-ordinators to release a hospital bed at short notice; referrals will also be made by the social care co-ordinators. This service is also available as an emergency service to GP’s to prevent an unnecessary hospital admission. Rapid Response is managed by the Slough Borough Re-ablement Service and is registered with the Care Quality Commission.

**Equipment**

Following assessment the provision of equipment may be part of the treatment programme.

**Outcomes Reablement Plan**

These are therapy assessed and produced programmes to enable service users to reach their maximum level of independence within the six week time frame.

4. **Access and Referral Process**

• Access will be through a single point of access; Reablement Co-ordinator, as described in the new social care model as part of the Hub.

• The service will be operational 24/7 in line with current PCT requirements.
Referrals will be made to the Enhanced Intermediate Care Service via telephone, fax and email through the single point of contact number.

The service will respond by telephone and in person to each referral within a two hour response time.

Referrals can be made through health and social care professionals in accordance with the criteria.

Each accepted referral will have an allocated social worker (care co-ordinator) who will remain with the service user/patient throughout the EICT / Reablement episode and will be leading the review that will lead to the exit from the service where the SBC eligibility criteria for ongoing services will need to be met, this is currently substantial and critical.

Hospital discharge referrals should normally be accompanied by an Occupational Therapy and Physiotherapy assessment.

The Reablement co-ordinator will follow up on any further information required in order to comply with the two hour response time.

The referrer is responsible for making any transport arrangements to either take service users home or admit to an Enhanced Intermediate Care bed.

Arrangements will be made by the team for transporting people from an Enhanced Intermediate Care bed to their own home.

5. What can service users expect (Service Standards and all essential standards of CQC)

- That the treatment they receive will be responsive to their needs.
- That the treatment they receive supports them towards outcome targeted independence.
- That the treatment provided is timely, flexible and of good quality, with due respect to privacy and dignity.
- That confidentiality is observed between the professionals involved.
- That any concerns expressed will be promptly and thoroughly investigated in all cases.
- That the standard of service will be in line with the Care Quality Commission.


Enhanced Intermediate Care:

Outcome Reablement Plan may include Rehabilitation, Physiotherapy, Independent living skills training, provision of equipment which includes the safe use of equipment and advice. Recuperation and recovery plans.

Rapid Response Reablement:

Service users will be assisted with relearning independence techniques with personal care which may include assistance and retraining in
wearing, dressing, using the toilet, food preparation, essential shopping and the taking of medication etc. Independent living skills training in the provision of equipment which includes the safe use of equipment and advice which will include assistive technology equipment.

7. **Service User Outcome Based Reablement Plan.**

Following a referral by a health or social care professional which meets the eligibility criteria, an assessment of need, risk assessment and a Outcome Reablement Plan will be undertaken by an Reablement Therapist. The Reablement Plan will be discussed with the service user, who will receive a statement of their assessed needs and agreed care/ treatment plan. Their agreement to the care/ treatment plan will be recorded on the plan and the service user will be given a copy of the plan. The Therapist / Reablement Assistants will work with the therapeutic/ Reablement Plan, making observations and liaising with therapists in the team. There will be a continuous review of need throughout a period of up to six weeks.

8. **Information for Service Users**

8.1 **Length of visit.**

Reablement Assistants will carry out their duties in line with the Reablement Plan. Sufficient time will be allocated for this activity dependent on assessed need all Reablement activity will be monitored via CM2000.

8.2 **Medication.**

Reablement Assistants will not carry out duties that should be performed by a trained nurse or other qualified health professional. If assistance to take medication is required, permission will be obtained from the service user or their representative and assistance provided in line with Slough Borough Council medication policy.

**Health and Safety**

All staff are provided with appropriate training to enable them to carry out their duties with due diligence.

Training includes:

- Manual Handling
- Risk Assessment
- First aid training and manga elk training

Key policies and guidance include:

- Slough Borough Council’s Health and Safety Policy
• Safeguarding Adults
• Medication Policy
• Risk Assessment policies
• Assessment and Care Management policies.

From time to time, new policies and procedures will be issued in line with legislative and regulatory frameworks covering health and social care.

For personal safety, the Enhanced Intermediate Care and Reablement Team are issued with Mobile Phones and Lone Working Policy.


Staff are not allowed to accept gifts or bequests from service users. They must not be a beneficiary or act as an executor to a service users last will and testament; neither are they allowed to enter into any financial arrangements. This includes lending or borrowing money and buying and selling between them and the service users. Staff or their family are not permitted to undertake any paid privately arranged work for service users.

11. Staff Recruitment and Training

Staff recruitment procedures will be consistent with the procedure established for any person applying for a post within Slough Borough Council.

• Interviews are conducted in line with recruitment procedures.
• Two written references will be obtained, one of which is a current or most recent employer.
• All staff are checked through Criminal Records Bureau.
• A comprehensive induction is undertaken by all employees before working alone with service users.
• All staff employed are declared fit to be employed through the Council’s Occupational Health Advisors.
• A file with all evidence / documentation is kept on the personnel file of all staff.
• Staff employed will have the necessary training, skills and knowledge to carry out their work effectively.
• All staff will be provided with a Job Description and Person Specification.
• All staff will undergo ongoing training and continuous training.
• All staff will be included in regular group meetings.
• All staff will be subject to a six month probationary period.
• Mandatory courses in manual handling will be provided on an annual basis.
• All staff will receive supervision, appraisal and personal development plans.
• There are policies and procedures in place to address any issues related to capability, disciplinary and grievance.

12. **Service User Records and Treatment plans**

The Enhanced Intermediate Care and Reablement Team comply with policies on:

• Recording
• Data Protection
• Retention and Destruction of records.

13. **Quality Assurance**

In conjunction with the Quality Standards Team, the Enhanced Intermediate Care and Reablement Team will work towards establishing their own quality performance assessments to produce quarterly and annual reports for analysis.

The team will collect one set of monitoring data that will be shared by Slough Borough Council and the Primary Care Trust. *(Data and protocols to be agreed as part of the governance arrangements)*

14. **Finance (Budget Arrangements)**

Slough Enhanced Intermediate Care Service is a pooled budget agreement between Slough Borough Council and Berkshire East PCT.

Slough Borough Council is responsible for the operational management of the service. This includes budget management. The service will be managed within the budget available. Any over-expenditure must be reported and corrective action taken to address any overspends.

The budget and expenditure in relation to this service will be jointly reviewed by the partners on a quarterly basis.

15. **Quarterly monitoring and Annual Service Review**

The service will be monitored by partners on a three-monthly basis and reviewed annually.

Below is an Outcomes Based Performance schedule and it is intended that as part of an annual review of the service these outcomes will be used to evidence positive outcomes and identify areas of good practice and areas for improvement.

**Outcomes Based Performance Schedule**

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>HOW DO WE KNOW?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Health and Emotional</td>
<td>EICT will evidence how the service</td>
</tr>
</tbody>
</table>
| Well-Being ‘I am as health as I can be’ | delivers improves performance against the following indicators:-  
NI 119 Self-reported measure of people’s overall health and well-being.  
NI 124 People with long-term conditions supported to be independent and in control of their condition.  
NI 125 rehab and reablement.  
NI 127 Self-reported experience of social care use.  
NI 137 Healthy life expectancy at age 65.  
NI 131 Delayed transfers of care from hospitals NI 131 (D41). – **Which ones of these do we want to keep??** |
| Improved quality of life and making a positive contribution ‘I am able to live a fulfilled life’ | EICT will evidence that they have a comprehensive process for collecting and responding to Service User feedback. EICT will demonstrate that this shows high levels of Service User satisfaction with their lives. This will include an annual User Survey. |
| Exercise Choice and Control ‘I have the same life chance as other adults’ | EICT will evidence the number and profile of people they are supporting who fund their own care or will go on to fund their own care. This will begin to give us a picture of the number of potential self funders in Slough.  
Maximise the numbers of Service Users using Independent Support Funds to maximise choice and control to support improvements against NI Social Care clients receiving self directed support. |
| Freedom from discrimination and harassment ‘I have an equal chance to live free from avoidable harm, fear, discrimination and prejudice’ | EICT will evidence how they actively promote and enshrine in their practice the needs of people in respect of their age, gender, disability, culture, race, nationality, religion, language and sexual orientation.  
EICT will report on numbers and profile of safeguarding investigations and will identify the number of staff referred to the ISA Barred List.  
Potential reduction in Best Interest referrals through DOLs, minimising accommodation changes by maintaining people in their current environment. |
Economic Well-being ‘I am financially stable and have as much control as possible over my money’

EICT will evidence how they support Service Users to achieve economic well-being and have access to work and or benefits as appropriate. The will support improved performance against NI 146 and NI 150 supporting Learning Disabled and Adult Mental Health Clients back into employment. – do we want to do this???

Maintaining personal dignity – ‘I feel valued by others’

EICT will be expected to provide evidence of how they support Service Users to feel they are treated with respect and listened to and have a sense of self worth. They will do this through the process of establishing Service User satisfaction.

Making a positive contribution – ‘I can participate as a full equal member of my community’

EICT will be expected to ensure that service users live, work, learn and participate in their community as equal members. Also that service users are involved in planning and decision making about the direction of their support and in the design and delivery of the services they receive. EICT will also document service users reporting a positive experience of their support.

Key Performance Indicators Quarterly Monitoring:

Set out below is a key data set that will be monitored quarterly.

The table below sets out the dataset requirements. These will need to be aggregated for the service but traceable to individual’s personal social care identifier. – can this be done Vicky?

For each individual receiving the service the EICT will capture.

- No of hours per week during the reablement period.
- Average length of the reablement period (by weeks).
- Circumstances of the client before the reablement period in particular recording the number of those who have suffered a stroke and the source of the referral.
- Cost of care before the reablement period.
- Measurement of impact of intervention on dependency levels against the following outcomes - impact of reablement on perceived quality of life; impact of reablement on social care outcomes and the impact of reablement on perceived health. This must consider.
  - Overall change between the pre- and post intervention.
• The degree to which Service Users change their response between pre and post intervention.
• The factor which impacted on Service Users responses before and after receiving reablement services.

Follow-up after reablement period:-

• Is the person receiving a package of care immediately after the home care period?
• Size, cost and nature of package.
• Is the person receiving a package of care 3 months after the reablement period?
• Size, cost and nature of package.
• Is the person receiving a package of care 12 months after the reablement period?
• Size, cost and nature of package.

All of the above will need to be granulated by:-

• FACs banding
• Age
• Gender
• Care group
• Ethnicity
• Postcode
• Informal care (where the Service User is receiving practical help from someone living in the same household or in another household.)