Discharge to Assess: Draft Service Specification
Pathways 2 and 3

SERVICE SPECIFICATION

Service	Discharge to Assess Beds
Commissioner Lead	**Kate Barker- Arden CSU on behalf of South Warwickshire Clinical Commissioning Group**
Provider Lead	**TBC**
Period	**01.11.13 until 31.03.2014**

1. Context

1.1. Strategic Context

1.1.1. The NHS South Warwickshire Clinical Commissioning Group Integrated Plan 2013-16 sets out the key strategic challenges that it faces in the next three years and its commissioning plan to tackle the issues.

1.1.2. NHS South Warwickshire CCG is expecting a high rate of population growth, particularly in the over 65s. In addition, Stratford-upon-Avon has the highest dependency ratio in Warwickshire. The growth of this group correlates with an increase in emergency admissions. Services for the frail elderly are not coping with the volume and therefore are not delivering optimum results for patients.

- Elderly people need more health and social care and make up the single biggest group of hospital bed users;
- 10 per cent of patients admitted to hospital as emergencies stay for more than two weeks, but these patients account for 55 per cent of bed days;
- 80 per cent of emergency admissions who stay for more than two weeks are patients aged over 65;
- An increasing frail elderly population means an increasing demand for healthcare and traditional beds;

1.1.3. The NHS South Warwickshire Clinical Commissioning Group Integrated Plan sets out its ambition to commission more co-ordinated services that are planned around the needs of the patient. Within its aim 'To build relationships with patients and our communities', NHS South Warwickshire CCG has set itself the target of improving the co-ordination and integration of services for the frail elderly in order to reduce emergency admissions by 10% by 2016.

1.1.4. For those who do need an admission to hospital, NHS South Warwickshire CCG has set itself the target to reduce Length of stay on the over 75s by 1 day during 2013/14 (10.5-9.5 days.) Reducing the time older people spend in hospital is important we know that if older people stay in hospital too long they will deteriorate.

1.1.5 People in the United Kingdom are living longer. At present there are 3 million peopleover 80 years old, a figure that is set to double by 2030.

1.1.6 The older we get the more dependent we become on hospital services and social care. The majority of patients in hospital and in the community are over 75 years old.

1.1.7 These people often have co-morbidities and complex conditions. An acute hospital is not the best place to assess their future needs.

1.1.8 In a recent 2012 King's Fund report 'The physical environment, working practices and care processes of acute hospitals geared to the model of acute medical care presuppose that the main task of the hospital is treatment and cure. However, care pathways and performance targets for waiting times and access to elective procedures are either irrelevant or actively obstructive to high-quality care for patients with complex conditions. These patients need reliable holistic (bio-psychosocial) assessment; multi-disciplinary care planning; advance planning to avoid predictable emergencies; care co-ordination; excellent nursing; excellent communication and collaborative relationships between staff, patients and carers.'

1.1.9 At any one time there are a number of elderly people in acute hospital beds, whose acute medical episode is complete but who are awaiting further assessment to decide what their recovery might look like in terms of their ability to function independently and the support they might need in the future.

1.1.10 In this context Commissioners and Providers are looking to build on ideas already being tested in Warwickshire for developing services which give patients access to the appropriate environment and expertise to enable a dignified and planned approach to the assessment of their future needs.

1.1.11 The Arden Clinical Support to Care Homes team role within the phase 1 of the D2A pilot was to contribute to the clinical assessment in the procurement process. The team provided mentorship and guidance during the pilot phase. The D2A service specification has been refined and the roles and responsibilities of the SWFT Community services and other agencies are clearly stated in the specification and D2A operating manual.

1.1.12 The Arden Clinical Support to Care Homes team will only be engaged in the D2A care homes in their capacity as quality assurance officers, if they have been requested for their clinical skills in the clinical monitoring processes. They are not available for direct patient referrals.

2. The Aims of the Discharge to Assess Service

2.1 To maximise peoples' capacity for independent living, increase the number of people able to remain living at home and reduce the number of people permanently admitted to long term care.

2.2 To support timely hospital discharge so that service users stay until their acute medical

episode is finished and then move to a more appropriate location for assessment of their future needs.

2.3 To provide an environment which helps people meet their rehabilitation and reablement potential and to become as functionally independent as possible, and a competent, skilled workforce who will support and encourage the individual service users to achieve their optimum functional independence, within the agreed care plans.

2.4 The Care Home resource for the South Warwickshire D2A project provides access to care home beds as a part of a locality resource to enable local health and social care services to provide rehabilitation/reablement through a "therapeutic offer", and appropriate assessment of adults outside of acute hospital settings.

2.5 To provide a supportive care environment whereby some degree of recovery/recuperation can take place allowing a more accurate assessment of care needs for those whereby returning home is unlikely to happen/ or not an option

2.6 The majority of service users who are referred and assessed for the D2A pathway, are likely to be Pathway 3 profile- frail, multiple co-morbidities and require access to 24 hour nursing care; the care provider must be able to demonstrate and provide a care environment and competent nursing and care workforce which can sustain and clinically manage this group of service users, to avoid unnecessary distress through readmission to secondary care.

3. Objectives

NHS South Warwickshire CCG, Warwickshire County Council and South Warwickshire Foundation Trust, through the mechanism of a shared purpose, are committed to delivering service changes that would:

- Maximise peoples' capacity for independent living, increase the number of people able to remain living at home and reduce the number of people permanently admitted to long term care;
- Support timely hospital discharge so that service users stay until their acute medical episode is finished and then move to a more appropriate location for assessment of their future care needs;
- Provide an environment which helps people meet their rehabilitation and reablement potential and to become as functionally independent as possible

3.1 To provide dedicated nursing care beds, in a distinct and separate area, within a Care Quality Commission registered Care Home, for residents from Warwickshire, who are registered with a South Warwickshire GP, and meet the eligibility criteria, and consent to be referred for access to the Discharge to Assess Pathways 2 and 3 as described in Appendix 1.

3.2 Service users are cared for in a way that facilitates a thorough assessment of all their needs.

3.3 Provide an "enabling" environment that promotes the short-stay nature of this assessment & therapeutic offer and emphasises independence so that service users have the best opportunity to meet their rehabilitation and reablement potential.

3.4 Build on current collaborative working with countywide Warwickshire health and social care colleagues to meet agreed milestones and goals.

3.5 Conduct robust evaluation to test the clinical and financial viability of the proposed model.

3.6 The D2A Pathways are a short term placement /relationship between the care home provider and the service user, whereby there needs to be active engagement with the care home provider, supported by the D2A multi disciplinary team to facilitate and work towards discharging service users from the care home within up to 6 weeks from admission.

3.7 To reduce duplication and increase service user and family/carer satisfaction with both assessment and care planning processes

3.8 To improve the standards and quality of integration of information sharing and workforce planning between primary and intermediate care and nursing care home workforce when implementing new Discharge to Assess care planning processes

4. Expected Outcomes

4.1 90% of all D2A service users have not been readmitted back into acute care 91 days post discharge from care pathway

4.2 95% of all D2A service users view their stay as a positive experience

4.3 D2A Service users meet expected rehabilitation and reablement goals, and have maintained these 90 days post discharge

4.4 The service provider will be audited for their access and response rates to assess compliance- to be confirmed

4.5 95% of all D2A service users stay in the Discharge to Assess beds is for up to six weeks or less.

4.6 100% of service users have a personalised care plan and which is reviewed at weekly D2A multi disciplinary team meeting

4.7 The expected core outcomes from the D2A service which will be measured across health and social care are

- Reduction in hospital length of stay
- Reduction in the numbers of service users needing Continuing Health Care and/or the CHC banding level of need
- Net neutral effect on social care through use of Community beds and pathways 1 and 2. i.e. if the level of need for CHC care package/expenditure reduces, we should not see a negative impact to WCC, with increased request for social care funded placements.

4.8 The Provider must do a quarterly population service user survey which must include questions of the impact of the D2A service/project on the other home residents

5. The Discharge to Assess (D2A)Service Model

5.1 D2A service users will transfer to a nursing care home, where they will engage in their full assessment of needs and risks to identify the long term care and support which they might require.

5.2 In addition to reducing the service user's length of stay in hospital, this will impact upon the potential for overstatement of needs that often occurs in acute settings when people are assessed at their most vulnerable in an unfamiliar environment.

5.3 Additionally assessment away from the acute hospital will facilitate a more relaxed and appropriate environment to engage with family and friends to enable informed long-term care decisions to be made.

5.4 The D2A care pathway model has 3 pathways:

- Pathway 1, supported discharge home;
- Pathway 2 where home is not an option at the point of transfer but permanent residential care is not inevitable; and
- Pathway 3, planned transfer to a nursing care home where D2A service user's' needs are very complex and where long term nursing home care is likely.

5.5 This specification is for services to support Pathways 2 and 3. The majority of service users will be for Pathway 3.The provider will actively manage service users on both pathways in a flexible and responsive manner recognising that some people may move from one pathway to another, as their level of need/support might change, especially on discharge from the care home.

5.6 The provider will work in partnership with members of the D2A multi disciplinary team, to promote the principle of "moving on" and support service users to achieve their assessed therapeutic potential.

5.7 The care home provider and their workforce will be responsible and accountable for directly informing the D2A multi disciplinary team and designated GP, at the earliest point they become aware of any service user and/or their family members, either expressing their interest to scope remaining in the D2A care home bed for any time beyond the planned assessment phase of six weeks.

6. The Service Description

6.1 Pathway 2 and 3: Referral and Acceptance Criteria

Pathway 2 and Pathway 3 is for adult service users predominantly aged over 65 years, who have completed their acute episode of care but are unable to return home, or to their usual

place of residence un-supported. This includes service users who have a cognitive impairment and need support, and/or may exhibit altered behaviour.

6.2 To consider for referral those individuals who have been identified via the South Warwickshire NHS Foundation Trust, "Discharging Patient's procedure (SWH-00565) from SWFT who are complex discharges as per Section 7.2, or Appendix C and the agreed access to D2A eligibility criteria:

- Resident in Warwickshire and/or are registered with a South Warwickshire GP
- Acute medical episode complete
- Are not diagnosed for "End of Life Care,"/Fast track/Palliative care
- If on anticoagulant therapy Rother House Medical Practice will provide access to local phlebotomy service; no local agreement in place for Castle Medical Centre yet- tbc
- May have a moderate to severe cognitive impairment.
- Has had a multidisciplinary assessment and have an agreed care plan, with evidence of measurable goals
- Requires access to 24 hour Nursing care
- A completed Medical and Nursing care D2A Discharge Summary
- Drug and Discharge Summary (TTOs)
- The D2A service user(or their next of kin, Legal Power of Attorney, IMCA as appropriate) will have given their consent to be considered for referral for the D2A pathway pilot
- A copy of completed unified Advanced Care plan which can be transferred between care settings.

6.2 Pathway 3 Referral and Acceptance Criteria

Pathway 3 is for service users who need a place to recover from the impact and consequences of an acute illness before an assessment can be made about their potential requirement of long term nursing care. This will include service users with a moderate to severe cognitive impairment.

Patients will have triggered positive for CHC checklist, but will not have had an assessment.

6.3 Assessment and Care Planning

- The hospital discharge co-ordinator will contact the nursing care home Provider about placing a service user only after;
- Discussion and agreement has been sought by service user and/or relative, and consent form has been completed. The requirement is that all service users referred into D2A pathway 2 or 3 will be suitable and medically safe to transfer. The service user's current acute medical episode is complete and they will have been reviewed by a consultant prior to discharge

- For Pathway 2- The individualised D2A care plan will set out agreed nursing care, rehabilitation goals and milestones. It is the expectation that the nursing care home staff will work to this D2A nursing care plan with input from colleagues from health and social care. The SWFT Community Therapy staff will be responsible for the assessment and define the individualised Therapy Offer for each service user,

and review this with both service user and care home staff.

- To actively encourage D2A service users to participate in social and planned interactive activity sessions within the care home.

- The provider's nursing care home manager will attend the weekly D2A multi disciplinary planning and review meetings, and provide individual service users record updates and progress evaluations

- The care home manager/assessor can decline to accept a referral if, in their judgement, the level of clinical need is beyond the care home's current capacity to care, and they recommend that it would not be in the service user's best interests to be transferred to the care home.

- For Pathway 3, a further CHC checklist will be planned for completion after service user has settled into new environment in discussion with MDT team. The outcome from the checklist and service users progress against their planned objectives will be reviewed to determine the next stage in their care planning assessment process, and if to progress to full CHC assessment, or social care assessment of needs.

- The nursing care home manager will be required to work with the D2A Social care lead and D2A multi disciplinary team to assist the service user and/ or their family to visit and review their future placement options, and manage the service users expectations to be "moved on" within up to 6 weeks of being transferred after their acute episode of care.

6.4 The Rehabilitation/Reablement Culture and Environment

- D2A service users will receive a high quality service that reflects outcome based care and support in a safe and supportive staffing environment using evidenced based nursing practices which meet all professional care standards.

- Care home staff must be able to demonstrate that they embrace the rehabilitation/reablement culture that supports independence. This means that wherever possible they will actively help and encourage D2A service users to look after themselves rather than looking after them.

- The service will provide care and support in an environment which will encourage social interaction and ensures that agreed outcomes are based on maximising personal independence.

- The provider will ensure that personalised care is delivered by respecting and involving people who use the service, staff respect diversity, maintain privacy and dignity and promote the independence of people who use the service.

- There will be a mutually agreed communication protocol on the referral process to SWFT Community services, clearly stating access, timescales, designated named contacts and any problems of access must be escalated to the D2A MDT lead and SWFT designated senior manager within 48 hours.

- The provider will contribute to the ongoing assessment of service user's

needs, with goals and interventions revised dependent on progress and recovery

- The provider will use and provide individualised nursing assessment and care planning system and record keeping, which will be reviewed with the D2A MDT, recording and monitoring essential information.

- The provider will create a local information leaflet, which describes their full complement of services and facilities which the D2A service user and their family can access, clearly outlining those services which are not available to the D2A service user, unless at a personal charge to the service user; e.g, laundry services, hairdresser, barber

6.5 Staffing Levels

- All the patients transferred to the Provider will be adults and most will be elderly but some will have more complex issues than others. The Provider must be able to provide nursing and care staff cover at all times to respond to service users who have the highest level of need, including those with cognitive impairment.
- This on site establishment must be justified through the use of an accredited skill mix tool, based on fluctuating dependency levels of all residents.
- There will be 24 hour nurse and care support that adequately supports the dependency and enablement focus of the patients in the discharge to assess beds.

- It will be expected that the staffing levels will reflect the need of individual service users and that staff will receive ongoing training to attain standards such as NVQ level 2.

6.6 Staff Skills and Competencies

The Provider is expected to undertake an audit of their current workforce training needs and report any gaps in either nursing care competencies or clinical skills. The Provider will provide evidence of an action plan to mitigate the gaps.

The provider will be expected to review and plan to ensure they can provide and sustain the range of nursing skills and competencies which will be necessary for the increase in bed capacity and needs of service users

The workforce is required to have the appropriate level of competencies, qualifications, skills and experience to meet the needs of D2A service users. The care provider should review their current nursing competency and skills re syringe drivers and implement an action plan to address any gaps

Clinical Skills

- Clinical assessment skills
- Access to appropriate clinical skills trainer to assess and ensure staff meet all training/competency skills required to meet care needs of clients/patients in D2A Care beds.
- Risk assessment and appropriate management of risk
- Ability to use information in undertaking assessments, clinical decision making

and diagnosis

- Experience and understanding of the presentation, progression and prognosis of common long term conditions and conditions associated with frail older people.
- High levels of communication and interpersonal skills and problem solving skills
- Knowledge and understanding of and the ability to apply the relevant legislation
- Understanding and application of the ethical issues involved in caring for older people with long term conditions
- Knowledge and understanding of health and well being issues for older people and people with long term conditions, and/or cognitive impairment
- The application of a holistic person-centred approach to care and rehabilitation that underpins the delivery of outcome focused care and support.
- Skills in identifying and protecting those at risk.
- Skills to actively manage people who are at risk of losing their independence.
- Knowledge and understanding of the impact of lifestyle choices
- Knowledge and understanding of the impact of social-economic and personal circumstances on older people and people with long term conditions.
- Ability to manage inter-professional and inter-agency working.
- The comprehensive list will be included in the Section 3 Quality Schedule; Module B, Section 3, Part 1
- The Provider / Nursing Care Home manager will liaise directly with the SWFT Locality team Leader and/or designated link Community "Care Home" Matron to access additional training if they identify they do not have the appropriate clinical skills to meet the needs of a patient. However, this could be at the expense to the care provider.
- If a potential D2A service user has any invasive feeding system, such as either naso gastric or enteral feeding system; to discuss the specific care planning and care interventions/ and nursing skills with the Care home manager and MDT prior to accepting the referral.

Skills to manage cognitive impairment, confusion and support mental well-being

- Knowledge and understanding of physical, behavioural, emotional and mental health needs
- Skills in interpreting response to long term conditions and changes in functional ability including recognising the signs of depression.
- Able to demonstrate knowledge and evidence of understanding of different therapeutic interventions which can be accessed and used in community services/settings
- The care home provider will be able to access and refer to the SWFT Community nursing resources in South Warwickshire, and integrated community therapy services for specialist advice and support.
- Knowledge of the local policy for referral for access to be considered for Deprivation Of Liberty Assessments as discussed within D2A MDT meetings with D2A GP Lead
- Knowledge and understanding of Mental Capacity Act 2005 and how to signpost

or access local resources, refer to D2A Operating Manual edition 1, 2013

6.7 Care Planning and Collaborative Working

Each D2A service user will have an assigned case manager from the D2A multi disciplinary team and will be supported by a local D2A General Practitioner whilst they are in the nursing care home for the period of their care assessment

The D2A GP and team and the Care Home provider will be able to access specialist advice when needed, for example Tissue Viability nurses and Dieticians, Speech and Language therapy from the SWFT Integrated Community Services team. Named point of contacts will be updated in the D2A Operating manual

There will be a weekly D2A multi-disciplinary meeting, attended by the designated D2A GP and Care Home manager to discuss the service user's progress against the agreed nursing care plan milestones and therapeutic goals and estimated date of discharge.

It is the expectation the Provider staff will attend the weekly case review meeting. They must demonstrate evidence that they are working with the patient to the agreed care plan. The Arden Clinical support nurses to Care homes will undertake planned audits of D2A care home documentation and report findings/feedback to the care home manager, within their contracting and quality assurance function.

To cooperate with the D2A multi disciplinary staff , to support each service user to achieve their assessed therapeutic potential and enable them to realise their choice in "moving on" from care home either before or up to within 6 weeks from admission

Each individual service user will have an individualised care plan, which includes a therapeutic plan, with goals, outcomes and review dates, to be monitored and reviewed weekly, with the service user wherever possible

An individual's progress will be assertively managed along the agreed care pathway with records of accountability made for agreed actions and reviews.

All admitted D2A service users will have a baseline weight recorded within 24 hours of admission, and at planned weekly intervals and prior to planned discharge date; if patient is receiving enteral or supplementary feeds to be reviewed with Community Dietician as to frequency of recorded weights, and monitoring.

The focus will be on working towards the patient's discharge with the expectation that the maximum length of stay will be up to 6 weeks.

The Provider will identify with the SWFT Community Therapy Lead if they need to access any additional postural or therapeutic/functional equipment to support the safe implementation of the individualised care plan. The Discharge Coordinator team leader will ensure that the additional equipment is made available as requested, and log all requests and resourced items.

Access to additional collaborative clinical or specialist support

The Provider will be able to access SWFT Community Nursing services for additional clinical Support and advice, if and when they need assistance or clinical supervision with a clinical intervention or competency training need. The terms of this arrangement will be reviewed and named contacts will be updated in the D2A Operating manual.

Access to Mental Health services for referral/support

The commissioner will confirm with the Care Home Provider the agreed access, referral and assessment processes with Coventry and Warwickshire Partnership Trust, in the event a patient request needs to be made, within the six week assessment phase.

Each patient will be discharged from the hospital with the following supplies :

- 28 days' supply of prescribed medication
- 1 week supply of dressings- if required
- Patients will receive a minimum of 3 days' supply of actual nutritional feeds/supplements from Pharmacy at discharge; the Care Home Provider will be responsible for arranging access to supplies in the community.
- The feeding pump and stand will be issued by SWFT. Nutrica are sent the serial number, and Nutrica monitor and arrange with the Care Home Provider, for the feeding pump to be returned to SWFT and cleaned.
- If a patient has an indwelling nasal gastric tube on discharge, additional appropriate size tubes will be supplied on discharge
- Giving sets, syringes, and connectors, "consumables" will be dispensed as a one week supply.
- The patient will not receive any supply of continence products on discharge from the hospital. It will be the responsibility of the Care Home Provider to provide any continence products and refer to the SWFT Continence Nurse Advisor for specialist advice.
- Catheter care is not provided by the SWFT Community support services, nor are catheter stands or drainage bags
- To agree with SWFT Community Services and D2A GP, access and prescribing of consumables and hiring of syringe drivers, if and when a D2A service user requires access to a syringe driver.

6.8 Medical Cover

Medical cover will be provided by a local General Practitioner (GP). D2A service users will be registered with the designated D2A GP who will be responsible for providing their medical care, in hours, Monday to Friday, during the patient's period of assessment.

There will be an operational agreement between the contracted GP, the Care Home Provider and the local commissioners until March 2014, which will outline the relationship and functions between the GP practice and the Care Home provider, to aid care, service user safety and communication and quality of services

- The contracted GP will be a designated member of the multi disciplinary D2A team and attend the weekly multi-disciplinary meeting. The GP will also be available in-

hours (Monday to Friday-) to respond to requests for advice for patients in the designated Discharge to assess beds if requested to do so.

- The Care Home will be required to use the out of hours GP service for any medical issues which occur after 5.30pm on Monday to Friday and between 5.30pm on Friday to 08.30 on Mondays.
- The designated GP will have telephone access to a SWFT Geriatrician, who is covering the acute admissions for the week

7. Accessibility

Access to a 24 hour, 7 days a week registered nurse care provision, with admissions according to the agreed criteria.

It is not expected that there will be any requests to transfer D2A service users from the acute hospital to the designated D2A beds in the care home outside of normal working hours (17.00-08.00). The D2A Discharge coordinator, GP and multi disciplinary team are only meeting to review potential referrals/admissions Monday- Friday.

The commissioned D2A Care Home beds are not available for any "unplanned" or emergency discharges from the acute hospital provider. The designated D2A GP is the accountable medical lead and responsible for agreeing admissions. This is not an out of hour's service.

Any exceptional requests to the Care Home Provider to consider accepting unplanned admissions outside of agreed care pathway processes must be refused logged and reported to both the Discharge Coordinator and Commissioner within 24 hours of the incident.

Any requests for a referral to the Care Home manager on site, to access any designated D2A bed must be within D2A pathway processes, from the Discharge Coordinator and agreed by the designated D2A GP.

Transport will be provided by the contracted Patient Transport Services for admission from the hospital setting to the Care Home Provider, and for any scheduled out patients appointments, during the period of the patient's assessment phase with the Provider, and for transport to the discharge destination form the care home; the provider will be responsible for booking transport

Patient Transport Services will not be available for any planned visits to alternative care homes sites, or social activity. The service will be available for planned booking for any attendances for out patients appointments/care assessments and when discharged from the D2A care home to final destination/placement

8. Referral Route

- The Provider will assign the Nursing Care Home manager as the referral Assessor, for the period of the contract, to be responsible for liaison working in partnership with SWFT Discharge coordinator, the D2A social care lead and the D2A multi disciplinary team, and to be the point of contact for referral, assessment and discharge planning.

9. Response Times

The provider will have a registered Nursing Care Home manager on site available and responsible for receiving and reviewing D2A referrals and assessments between 9am-5pm, Monday to Friday.

The provider will allocate a lead D2A clinical nurse, for each shift, to be responsible for organising the day to day care management planning and care support to D2A service users when in the care home. The lead D2A clinical nurse will be separately identified on the daily D2A staff rota, and be a separate resource for the period of the current contract D2A to March 2014.

The provider will respond to a request for assessment from the SWFT Hospital Discharge coordinator between 9am and 5pm, Monday to Friday

If the referral is sent from the discharge coordinator to the care home in the morning, the care home manager will assess the same day with a view to accepting the same day, (if feasible), if referred after 14.00, they will assess the following morning.

If a designated D2A bed is available the Provider will arrange for planned transfer of the service user within 24 hours of the decision for admission from hospital

The provider will ensure that the D2A GP and hospital discharge coordinator team, are informed of any patient on the D2A pathway that is readmitted to the acute, in and out of hours, and the reason why

The provider should contact the D2A GP and Discharge Coordinator, should a D2A service user have a rapidly deteriorating condition, whereby “Fast track” Continuing Health care consideration is required.

The Provider will ensure that the hospital based Discharge Coordinator and team is kept updated on a daily basis on the current bed status, and/or if any D2A service user or their family is expressing concerns about refusing to move on or be discharged as planned

The Provider will inform the hospital based Discharge Coordinator if and when on assessment, the referred service user does not meet the D2A referral/eligibility criteria for the nursing care home, or the care home requires additional staff training and competency based skills to ensure they can safely meet the care needs of any service user.

10. Discharge Criteria

- Each D2A service user will be reviewed and assessed for a planned discharge if:
- They are assessed to have met the rehabilitation/ reablement goals in their care plan; or
- Their ongoing needs of the patient can be met at home with or without ongoing community support services- (Pathway 1)
- A transfer of care is required to meet identified nursing care needs; or

- There are identified long-term care needs within another environment.

- Individuals will not be transferred to any other care setting without the consent of the individual, and prior discussion with the D2A multi disciplinary team including evidence of ongoing case management and care plan
- Planned Discharge will be facilitated by the D2A multi disciplinary team and D2A Social care lead which meets weekly, and the Provider will attend this, to represent both the provider and the patients placed within their setting.

- If a service user is unable to improve/achieve their self care outcomes/therapeutic goals by week 4, the Provider is to cooperate with the D2A Discharge planning team to support and update the patient on their ongoing care options, and actively implement the options from the review meetings, and provide consistent information to the patient, and their family, on their expected date of discharge, choices and plans.
- There will be no guarantee made to any service user admitted to the D2A care pathway, that their care placement options on discharge from the D2A assessment phase, will include the Provider.
- In the event of the death of a D2A service user, the care home provider will continue to allocate the bedroom up to a maximum of three working days, before commencing cleaning, to enable the bedroom to be reallocated. Any uncollected personal property will be the responsibility of the next of kin.

11. Monitoring and Performance

The provider will support data collection to inform whether or not key performance indicators have been achieved, within the agree reporting schedule
In situation where the Provider is not meeting the service specification expectation, or CQC non compliance, commissioners will trigger the Warwickshire County Council and Arden Commissioning Support Unit contract monitoring processes, and the Provider will be expected to provide a remedial action plan within 10 working days.

Performance Indicator	**Measurement**
95% of staff have a positive view of the contribution by other team members	All staff associated with service to complete survey- to be developed with D2A MDT
95% of all service users report that the stay has made a positive contribution to their rehabilitation	All patients are asked to complete a survey on their discharge
100% of all service users have a personalised care plan containing goals and milestones and signed reviews	Audit of care plans
95% of all service users have a length of stay of up to 6 weeks or less	Audit of length of stay
95% of service users are transferred from the acute hospital to the designated nursing care home within 24 hours of referral	Audit of referral, record of number of delayed individuals and number of bed days

95% of all calls from nursing care home to General Practitioner are assessed as necessary when using the D2A assessment algorithm between Nursing Care home and General Practice	Audit of logged calls and assessment sheets by D2A GP and commissioner, formal feedback on key themes at MDT meeting with Care home manager and D2S lead clinical nurse
100% of D2A service users referred are accepted by the care home if a bed is available, and if the referral is appropriate	Audit of number of referrals to care homes, how many are accepted and reason if patient not accepted

12. Environment

The Service must provide a clean, safe, homely and non-institutional environment. It must provide for the privacy of individual patients.

- The care provider should notify the D2A discharge coordinator of any outbreak of infections that may impact on capacity/accessibility to the D2A beds.

- Each establishment is equipped and furnished in ways which promote and enhance the patient's independence. It will be the responsibility of the Provider to insure, maintain and/or replace as appropriate any equipment in the Care Home to ensure a safe and protective environment.
- The service will notify the hospital based Discharge Coordinator Team leader if and when they are advised to provide additional short term functional or adaptive/postural therapeutic equipment, to enable the patient to achieve their goals. The Discharge coordinator will arrange access to the Integrated Community Equipment service.

- The Service must also promote opportunities for patients to participate in all domestic activities, enjoy ordinary community based activities, pursue leisure interests of their choice and utilise community facilities to the full.

- The Provider will ensure that the SWFT Discharge and D2A MDT team have access to available information about the current service description, facilities and materials, which can be shared with those individuals who are giving their consent to be discharged to the Provider.

- This might include recent Care Quality Commission monitoring evaluation/report, client user satisfaction, complaints/compliments, user feedback summary.

- The Provider will ensure that they can provide evidence of the procedures to enable an individual/ client, their family/carer can give their feedback, or observations about their experience with the Provider.

- The Provider must supply access to the essential equipment as specified in Care Quality Commission Nursing Care Home regulations; any additional specialist equipment for either postural or therapeutic care for the D2A assessment phase will be reviewed on a case by case basis and agreed by the designated/authorised SWFT Community Lead. Any additional equipment will only be supplied for the period of the D2A assessment, and will be returned to the SWFT ICES at the end of the assessment phase.

13. Registration, Inspection and Monitoring

The Provider will be registered with the Registration Authority and this Service Specification should be read in conjunction with the relevant Registration/Inspection Standards which will prevail as the Service Specification required under the Contract in the event of any conflict between the two.

The Provider will forward to the Warwickshire County Council Contracts MonitoringTeam copies of all: notices, notifications, inspection reports and quality reports as issued by the Regulatory Authority to the Provider. This includes the provision of any of the foregoing when in draft status, ahead of any formal publication. The Provider must give permission for the ACS to access any of the foregoing directly from the regulatory body. The Provider will be responsible for notifying the Warwickshire County Council Contracts team regarding any enforcement or regulatory action being undertaken by the Regulatory Authority.

The Provider must allow officers of both the Arden Commissioning Support Contracts team and Warwickshire County Council's Peoples Group contract team to access all information about any of its Customers or the care home(s) itself and provide copies of all such information when so requested.

The Provider shall allow an officer authorised by the County Council to visit the Care Home or the Customer at any time without notice and to inspect the records and interview staff and Customers in connection with the Service or the performance of the Contract.

14. Quality Assurance

Each area covered in the Service Specification will be regularly audited according to Service requirements. This will be achieved by monitoring mechanisms, which will be a combination of the statutory inspections, by service contracting processes, individual Customer reviews and the monitoring of complaints, concerns and commendations. In addition, monitoring information will come from family/carers other professionals and advocates where appropriate.

There will be occasions when the commissioner may consider suspending further placements at the Care Home. This will be in situations where there are concerns relating to serious breaches in the contractual arrangements with the Care Home, or allegations under the Safeguarding of Vulnerable Adults Procedures.