SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement
Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	001
Service	Residential Intermediate Care Beds - Adults
Commissioner Lead	
Provider Lead	
Period	1st April 2018
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Strategic Context

Blackburn with Darwen CCGs are expecting a high rate of population growth, particularly in the over 65s and 75s over the next 10 years. The numbers of people over 75 are projected to increase by 36% in BwD in the next 10 years. The numbers of people over 65 are projected to increase by 19% in BwD in the next 10 years.

Elderly people need more health and social care and make up the single biggest group of hospital bed users:

- Locally, 49% of acute unplanned bed days are occupied by people 75+, and two-thirds of beds in the hospital are occupied by people 65+ on a daily basis.
- Nationally, 10% of patients admitted to hospital as emergencies stay for more than two weeks, but these patients account for 55% of bed days and 80% 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 transitional beds:

- The older we get the more dependent we become on hospital services and social care. The majority of patients in hospital and receiving support in the community are over 75 years old. These people often have co-morbidities and complex conditions. An acute hospital is not the best place to assess their future needs.
- Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - the National Audit Office reported that between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.

Patients hospitalised for acute episodes are at risk of experiencing significant loss of functioning as a result of inactivity, immobility and, in some cases, prolonged bed rest. This risk is generally increased in patients with complications, during long-term stays, in persons with disabilities, in patients with pre-

existing chronic conditions, the vulnerable and the elderly. It is recommended that loss of functioning should be addressed as early as possible during an acute hospital stay in order to minimise further loss and to optimise recovery and early autonomy.

Early identification of rehabilitation needs and early commencement of rehabilitation can also reduce length of stay and help prevent disability. It is expected that early rehabilitative intervention takes place in the acute setting within the initial treatment phase.

Sub-acute rehabilitation provides multidisciplinary services to restore or enhance function post injury or illness. Patients requiring sub-acute care typically do not require acute care services but continue to require short-term, nursing and medical input and rehabilitative interventions provided by a specialist medical and therapy team with experience of rehabilitation and re-ablement. This new service will form part of a range of personalised and coordinated rehabilitation services, ensuring that patients obtain the right services in the right place delivered by the right professional and at the right time for the patient.

Blackburn with Darwen Clinical Commissioning Group and Blackburn with Darwen Borough Council, working closely with our partners, intend to commission a new model of service to be delivered for rehabilitation patients shaped on the needs of those patients. This service will develop close working relationships across organisational boundaries to deliver a seamless service. We believe this new model of service will improve health outcomes for this cohort of patients, in line with the intentions set out in the Government White Paper 'Equity and Excellence'. We are therefore investing resources in services to deliver an improved rehabilitation and recuperation service pathway. This specification for the provision of assessment, short term rehabilitation and sub-acute services therefore contributes to an improved, integrated pathway for patients.

This service specification draws on National Service Frameworks (NSFs) and National Stroke Strategy and guidance from organisations such as the Department of Health (DH), British Geriatric Society (BGS), British Society Rehab Medicine (BSRM), Royal College Nursing (RCN) and Royal College Physicians (RCP).

Values

The CCG and Council wish to operate in partnership with Providers and other organisations in delivering high quality support to its service users and together move towards outcome based approaches to the purchase and provision of this service. This will be developed by all parties throughout the duration on the contract.

The commissioners seek to obtain best value, for all key stakeholders, throughout the duration of the service.

The commissioners expect the service to be provided in a manner that accords with the statement of principles set out below and also expects the provider to perform the duties required in accordance with best and evidence based practice. These principles should be applied to the services provided.

The provider will have clear written measurable objectives to agreed standards for each area of service delivery. These objectives and standards must take into account meeting the needs of individuals and where practicable, taking the views and aspirations of the individuals and care workers into account.

Each person should be respected as a unique individual, with recognition being given to his / her particular physical, psychological, social, emotional, cultural and spiritual needs.

People in receipt of the service should be enabled to lead as independent a life as possible so that their ability to exercise choice, to live their preferred lifestyle and achieve personal fulfilment is maximised. The right of an individual to make his / her own decisions and choices and to incur calculated risks should be respected and supported.

Each person should be treated as an individual with rights and responsibilities, and be recognised as a valued member of the community who can make a contribution to society.

Care and support should be provided in a manner that offers confidentiality, respect, dignity and privacy and not undermine individuals' ability to self-care or the contribution made by family carers.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Social Care Outcomes Framework Domains & Indicators

Domain 1	**Enhancing quality of life for people with care and support needs**	**X**
Domain 2	**Delaying and reducing the needs for care and support**	**X**
Domain 3	**Ensuring that people have a positive experience of care and support**	**X**
Domain 4	**Safeguarding people whose circumstances make them vulnerable and protecting them from harm**	**X**

2.2 Local defined outcomes

Intermediate Care, by definition, straddles a number of interfaces between different forms of care. It is about partnerships between individuals and organizations to ensure that services are person centered, promote faster recovery from illness, prevent unnecessary acute hospital admissions, prevent admission into long term care, support timely discharge and maximize independent living.

Key service outcomes include:

- Reduced admissions and GP direct admissions to acute hospitals;
- Reduced admissions into long term care;
- Provision of evidence based rehabilitation programmes;
- Increase in individuals independence levels to support them to be discharged home;
- Improved co-ordination flow and quality of patient experience;
- Improved clinical outcomes; patients goals are met;
- Reduction in requirement of long term care packages;
- Reduced length of stay in an acute setting;
- Workforce is optimised; through the upskilling of roles and the coordination of tasks;
- Contribution towards a reduced utilization of emergency secondary care services;
- Reduced A&E attendances;
- Reduced AMU referrals and admissions;

- Improved care co-ordination and system responsiveness, integrating all elements of care;
- Improved patient and user satisfaction, reported outcomes and quality of life.

Some of the key measures that should be monitored locally include:

- sources of referral;
- reasons for referrals not accepted;
- case mix of referrals;
- timeliness of responses;
- time from referral to admission/transfer;
- number of delayed transfers of care;
- length of stay;
- discharge destinations at various intervals;
- readmission rates;
- change in functional capacity before and after intervention;
- exception report for stays over 6 weeks;
- NWAS call outs

In terms of outcomes and KPIs the following should be monitored:

- Readmissions – during stay and 90 days post-discharge
- Telemedicine activity
- Number of CHC assessments taking place and MDT decision

3. Scope

3.1 Aims and objectives of service

The aim of the service is to provide a short term residential intermediate care service consisting of step up & step down beds with rehabilitation. The service will empower service users to recover from episodes of ill health and to return home through the provision of individualized support providing therapy, care, medical oversight and nursing, where applicable. The service is designed to optimise an individual's level of independence enabling them to resume living at home.

The overarching bed base will include:-

- Active convalescence/recovery beds – allowing time to recover/gain strength before commencing therapy
- Residential rehabilitation beds – non-clinical, step up & step down with therapy.
- Sub-acute beds – Clinical care & Therapy with medical oversight step up & step down.
- Sub-acute 'plus' beds – reflecting additional nursing requirements in line with Intensive Home Support principles to prevent hospital admissions. These could be step up and step down.
- Capacity to support discharge to assess beds preventing any assessment of need being carried out in an acute hospital bed will be configured within the overall bed base.
- Short term Care beds to be utilised whilst service user awaits package of care/ house adaptations.

The service will:

- Provide a step up & step down facility for patients that cannot return to home but do not require acute care
- Provide rehabilitation, care support, nursing and medical oversight required to meet a patients needs
- Promote individual independence, self-care and well-being. This incorporates health promotion and both physical and psychological care.
- Provide evidence based treatment programmes to these service users to maximize their independence and well-being.

- Improve health and function ability.
- Transfer as appropriate to home as the first option or a place of residence in the community within a pre-defined period of time and in any case usually within six weeks of admission to the home.
- Make use of technology in promoting independence and self-care
- Will work in partnership with patients, families and carers
- The service will be expected to carry out Continuing Health Care (CHC) Assessments

3.2 Service description

Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. The initial Department of Health guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria.

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- Carry out 3 x weekly MDTs
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Service pathway

It is expected that the residential intermediate care beds will be access via a single pathway and using consistent assessment criteria eg the trusted assessment document. There are two directions of patient flow:

1. Supported discharge, which enables patients to be discharged safely and efficiently from hospital back to their own homes, or to an intermediate care residential bed on a **step-down** basis and

2. Admission avoidance for community-based **step-up** referrals for patients in their own home to prevent admission to hospital

Individual patients undergoing a CHC assessment Would still be appropriate as discharge to assess. The provider will be expected to have a designated co-ordinator to liaise between all stakeholders to ensure appropriate admissions and timely discharges to wider community services.

Step up – Via social work or clinical assessment, or case finding in integrated locality teams, an individual may be identified as appropriate for residential intermediate care for example where community health and social care teams identify people with the need for enhanced support for a period of time to delay or reverse deterioration of functioning. The identified professional will contact the unit and make arrangements for admission, liaising with the designated unit social worker and therapy professionals to agree the appropriateness of an admission to the unit, on discharge the individual will return to the overarching care of the locality team.

Step down – Individuals will be identified through the daily Integrated Discharge Service discussions, a trusted assessment document will be completed and passed to the BwD step down service who will ensure the completing of the trusted assessment document and will liaise with the unit, individual and ward to facilitate a timely discharge

The individual will then be transferred to the caseload of the designated unit social worker and onward

through discharge to the integrated locality team where appropriate.

The trusted assessment should lead to an intermediate care plan for each individual, with a team member making sure that it is carried out. The individual and their carers should be key participants in any decisions made.

The service will receive referrals from:

- The Intermediate Care Team to prevent hospital admission and support early discharge;
- ELHT hospital and locality-based social work teams;
- The Integrated Discharge Service;
- Intensive Home Support Service;
- Intermediate Care Allocation Team;
- Navigation Hub.

Shared working protocols and documentation, weekly reviews involving the client and appropriate professionals, multidisciplinary team meetings and performance management between services will be necessary to ensure timely transition in and out of intermediate care with other social care or health services.

Once goals are achieved, where appropriate, the service user will be discharged, or referred to another service. This process will be arranged through the designated social worker, where needs have been identified appropriate to care Act eligibility; this may include domiciliary support, reablement, short term care and direct payments as examples. The social worker will also identify with the client if a referral to third sector organisations would be beneficial and also consideration would be made for a referral to the integrated locality team.

Where the client does not access a social work assessment and discharge planning process this will be supported with information and advice from the unit manager to ensure safe and appropriate discharge; in these circumstances referrals can be made directly to third sector and integrated locality team resources.

It is the intention that the resource will host outreach services to assist clients to maintain the optimum recovery achieved through the rehabilitation period, and this should be discussed and planned with the client before they are discharged from the service.

Service requirements

The provider is expected to attain the requirements set out in Appendix A in relation to CQC registration, service delivery and quality standards.

3.3 Population covered

The service will be provided for the registered and resident populations of Blackburn with Darwen CCG. Our population has 150,000 residents, and 172,551 registered patients. The services apply to adults [individuals 18 and over], meeting the Council's Social Care Services eligibility criteria and seeking the provision of care services. At times of high pressure the facility may be requested to accept out of borough patients. This will be facilitated through a jointly agreed protocol and pathway between the relevant commissioning bodies.

3.4 Any acceptance and exclusion criteria and thresholds.

The service will:

- Support equitable access based on the rehabilitation needs of the individual. It will not discriminate on the grounds of age, gender, sexuality, ethnicity, disability or any other non-clinical factor.

- The service is for adults over the age of 18 years, registered with a General Practitioner in Blackburn with Darwen. While the community intermediate care inpatient service is likely to have a particular importance for older people, service planning should take into account the needs of all potential service users.
- Facilitate access to appropriate support to meet the patients' needs on request e.g. a professional translation service and materials describing procedures and clinical prognosis to non-English speaking patients, information in large print, Braille etc.
- Include those patients who are undergoing active medical investigations.
- Accept referrals between 08:00hrs and 20:00hrs. Contingency plans will be in place between 20:00hrs and 08:00hrs Monday to Friday. Referrals will be accepted on the basis of the Trusted Assessment via Integrated Discharge Service (IDS).

Admission criteria

- Adults aged 18 years and over
- Have identified reablement/rehabilitation needs
- Are medically stable
- Have outstanding health needs that require 24 hours qualified nursing (sub acute beds)
- Has the cognitive ability to benefit from a rehabilitative programme
- Individuals who lack capacity to agree to rehabilitation but would benefit from the programme and is able to participate.
- Have identified short term goals that can be delivered within a 3 week timescale with a maximum of 6 weeks
- Have a BwD GP

Exclusion Criteria

- The individual's condition is not medically fit to be in an intermediate care setting.
- Individuals with challenging behaviour where it is assessed that the individual would be unable to follow a rehabilitative programme
- Individuals that pose a risk to other staff or residents.
- Individuals that require 1 to 1 supervision.
- Where coordinated multidisciplinary care is not required.
- Documentation in the medical record does not support the need for intensive residential/nursing rehabilitation.
- People for whom consent to participation in rehabilitation due to mental capacity issues is not established (considered on a case by case basis by the MDT).
- People with acute nursing care needs where their case has been considered on an individual basis and is considered ineligible for the service and where there cannot be oversight of care by acute nursing services.
- People who have the capacity to return home via the Intensive Home Support Service
- People whose need for rehabilitation and reablement can be managed in their own home
- People who have been assessed as needing a permanent care home placement
- People of working age presenting with an acute mental illness where there is no treatment programme and the person's condition is unstable.
- People of working age with needs relating to substance misuse, because these services are provided elsewhere.
- People on a fast-track End of Life process

Patients with:

- Persistent Vegetative States (PVS).
- Behavioural problems that would affect the individual's outcome and those of other service.
- Users/patients.
- Patients detained under the Mental Health Act.
- Complete spinal cord injury.
- Patients who are not medically stable.

Where the provider has chosen not to accept a referral into the service this will be documented and shared with the commissioner on a monthly basis as part of the contract monitoring system and reporting.

3.5 Interdependence with other services/providers

The Services are part of wider integrated adult health and social care services that are commissioned by Blackburn with Darwen CCG and the BWD council. The Provider and Commissioners will work in partnership with GPs and Integrated Locality Teams (ILT), Lancashire County Council, Acute and Community Providers, Community Mental Health Teams, the Voluntary and Community sector, and Independent Providers (this is not an exhaustive list). The Provider is expected to be working currently with these other organizations to support Service Users and their carers to successfully manage the Service Users' conditions. They should as a minimum have a well-developed pathway for communication with GPs and the wider health, voluntary and social services environment. The service is dependent on other NHS and social care services for referrals into the service and discharges to community services. There is reliance on patient transport for the transfer of patients between services.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The provider will maintain Care Quality Commission registration and adhere to the Essential Standards of Quality and Safety. It is expected that Service Providers ensure that policies, and procedures and practices are regularly reviewed and that the following list of standards/good practice guidance is where appropriate adhered to:

- The National Service Framework for Older People
- The National Service Framework for Mental Health
- Department of Health (DOH) Guidance as issued
- Care Act 2014 - Department of Health
- National Institute for Clinical Excellence (NICE) Standards
- DOH Guidance on Infection Control
- The Administration and Control of Medicines in Care Homes – Royal Pharmaceutical Society of Great Britain
- Mental Capacity Act 2005

4.2 Applicable local standards

All Providers must evidence how they meet the following local standards:

- Clinical Governance
- Record Keeping
- Medicines Management
- Safeguarding

a. Services will be delivered in line with local safeguarding policies and guidelines - to include training for all staff in local policies and procedures.
b. Services will fully respect and respond to diversity and cultural differences and adhering with the Equality Act providers ensure that reasonable adjustments are made as appropriate
c. The service will have in place arrangements for managing pressures associated with vacancies and staff absence to ensure that service safety, quality and consistency are not compromised, including early communication with commissioners in the event of potential difficulties that may arise in order that the situation can be effectively managed.
d. The service will have effective risk management systems in place and report SUIs to commissioning bodies
e. The service will undertake audit in agreement with and sharing results with commissioners.

2.10 Quality assurance requirements:

The provider will have an acceptable method of quality management as part of their overall service management process. Quality management will emphasise self-monitoring of standards by staff involved in service delivery at all levels using a process that allows independent scrutiny and validation. A focus on review and planned improvement will be expected. Quality, safety and safeguarding will be expected to be a strategic and operational priority.

In addition, the provider will ensure that the individual is invited to complete a written customer satisfaction document at the end of their rehabilitation programme, or at any time he/she wishes as a means of acquiring feedback regarding service delivery.

The provider is expected to have its own complaints procedure which should be made available to the authority. Evidence that outcomes from complaints are used to improve performance, and influence changes in policy will be required as part of the quality assessment process. Providers will work with the authority on requests for monitoring information and regularly submit reports on the services i.e. that provider performance will be taking corrective action where necessary to remedy poor performance. Providers will also be required to attend a monitoring meeting every six months or as and when required with officers from the authority.

2.11 Quality:

The provider will have clear written measurable objectives to agreed standards for each area of service delivery. These objectives and standards must take into account, meeting the needs of individuals and where possible taking their views and aspirations and those of their carers into account. The objectives and the processes and procedures related to these objectives must be regularly reviewed and where necessary redefined and amended.

Providers must be able to provide evidence when required by the authority, of action taken to improve and embed practice where necessary.

2.12 Contract monitoring:

The provider is required to provide information to meet the monitoring requirements stipulated within the contract. Contract reviews and monitoring is the regular process undertaken by the Council to ensure that providers comply with the requirements of the contract and are performing effectively. Contract reviews will be undertaken every 2 months. Providers will be notified prior to the contract review and will be issued with a report card to complete prior to the review meeting taking place.

4.11 Notifiable instances and accident/incident reporting:

The provider shall inform CQC of notifiable instances per the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, as set out by the Care Quality Commission in the Essential Standards of Quality and Safety. The provider will copy the council into such notifications. Providers will maintain accident and incident logs for both staff and individuals supported and make these available to the council. Providers will be expected to review and risk manage their processes following any accidents or incidents. Where accidents or incidents are considered high risk then the provider should contact the council's social work team without delay to inform them.

4.12 Difficult behaviour:

It is recognised that some individuals can present challenging behaviour which can cause difficulties for the provider. It is anticipated that where such behaviours are identified, early liaison is held with commissioning officers and the nominated social worker to address the issues so that withdrawal of service can be avoided where possible.

Situation where the individual continues to present violence, aggression or unacceptable behaviour and risk management strategies have not been able to minimise the risk sufficiently, the provider may serve notice that the individual is not able to remain in the service , notifying the authority's social work team

before taking any immediate action. In considering such an action, the provider must take account of the vulnerability of the individual and the risk presented to him/her. The social work team must advise the provider of the individual's care plan and alternative arrangements to be made.

4.13 Safeguarding adults:

The provider is expected to work in line with Blackburn with Darwen Safeguarding Adults Board (LSAB) multi agency Safeguarding policy and procedures and co-operatively with all statutory bodies and legal representatives.

It is expected that the provider will ensure that the six key principles of safeguarding underpin the service provided. These principles are:-

- Empowerment: *Personalisation, person-led decisions and informed consent*.
- Prevention
- Proportionality – *Proportionate and least intrusive response appropriate to the risk presented.*
- Protection – *Support and representation for those in greatest need*.
- Partnership – *Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.*
- Accountability – *Accountability and transparency in delivering safeguarding*.

All staff must have an awareness of safeguarding adults procedures and all care staff are expected to be trained in the Safeguarding Adults process (including Mental Capacity processes) and have a detailed understanding of how the process works.

The responsible managers for the service will need to ensure that the process is followed in a robust, timely and efficient manner and the organisation has arrangements in place that are Care Act compliant. This process will be audited under QAS and contract monitoring procedures and by the LSAB. Outcomes from Safeguarding Adults investigations will be fed into process changes and service improvements. The safety and well-being of all vulnerable adults is the responsibility of all carers is a key statutory duty of the council and in providing these services the provider is acting on behalf of the Council.

The provider must have in place policies and processes for reporting of abuse in line with the BwD Safeguarding Adults continuum to suspected abuse/neglect, including whistleblowing policies and procedures.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
TBC

7. Individual Service User Placement

Appendix A – Service Requirements

It is a requirement that all providers will be registered with the Care Quality Commission (and any successor body) and will maintain registration throughout the duration of this contract. Failure to maintain registration will render the contract void.

Providers are required to give assistance to in individuals which will meet their assessed care needs and will often include elements of personal care and other tasks as defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and as set out by the Care Quality Commission. The tasks and outcomes to be delivered will be described for each individual on the support plan completed at the time of the first commissioning the residential rehabilitation service and then updated in consultation between the named professional responsible for the individual package of care, the service provider and the person as needs change. . The authority expects all providers to be compliant with the essential standards of quality and safety as monitored by the CQC.

The number of care workers, therapy resource and other staff on duty at any one time shall be adequate to meet the care requirements of all individuals at the time as identified in care support plans. Staffing levels will be reviewed on a regular basis in line with the changing needs of individuals and will ensure that the requirements of all individuals utilising the service are met.

The provider must incorporate the following activities and approaches in the service in order to maximise the ability of each individual to live independently;

(a) In all aspects of service delivery the needs of the whole person (i.e. physical, psychological, social, emotional and spiritual) should be taken into account. This will require staff to spend time gaining an understanding of the individual's life history, personality, mental and physical health, relationships, attitudes and aspirations. The planning or provision of any service should always be approached from the individual's perspective.

(b) Services should be designed to achieve the maximum rehabilitative effect and optimum level of independence. As well as assistance with physical rehabilitation, this will include ensuring that appropriate aids and equipment are available, assisting in the learning or relearning of skills and techniques necessary for independent living, the provision of encouragement and support to rebuild confidence or self-motivation etc. It is important that where they have the ability, individuals are supported in carrying out tasks for themselves even though it might be quicker for staff to undertake the task directly.

(c) The service user should be made aware of range of preventative services should be provided to enable individuals to take action to preserve or promote their own health and wellbeing. These include advice and information on healthy living and safe practice, as well as opportunities for maintaining physical fitness, good nutrition and a positive attitude to ageing and disability. The use of telecare and telehealth will also be used to complement and / or reduce the need for care and support.

(d) Services provided should be flexible, responsive and capable of change at any time upon the wishes of the individual. Individuals should be able to exercise control over the timing and type of assistance they receive for tasks they cannot do themselves, as far as practicable. The provider will lead service delivery but will ensure that the above principles are followed.

(e) Each individual should have a flexible care and support delivery programme, based on the assessed care plan and reviewed through regular multidisciplinary team meetings, which identifies targets and outcomes, agreed by each Individual, their family carers and the provider

(f) The provider will allocate a key worker to each individual.

(g) Day to day changes in the abilities and needs of each individual should be monitored and responded to.

(h) A 'shared care' approach should be adopted where the provider's staff work with an individual and family carers in the family home to carry out agreed tasks.

(i) The Provider shall ensure that appropriate facilities and equipment available are used to:

i. Enable the full range of care needs to be met e.g. hoists, assisted bathing facilities, incontinence, laundry management, etc.
ii. Make sure the service and delivery thereof complies with health and safety requirements.

(J) Staff should use the least restrictive support methods which safely manage risks. Physical or medical control and restraint should only be used in exceptional circumstances, based on agreed protocols and risk management strategies.

(k) Support staff will receive up to date training in best practice for supporting vulnerable people.

(l) As far as possible to enable people to achieve their own solutions to problems. To attain this objective it will be necessary, subject to the individual's choice, to involve them in the processes of a comprehensive assessment of need and service planning. It will also be necessary to ensure that they are provided with full information on which to base decisions.

(m) To facilitate effective collaboration with other statutory bodies and other agencies in the assessment of need and the delivery of services.

(n) Individuals should have the right to personal space and privacy for themselves, their belongings and their affairs.

(o) Individuals should be supported to maintain contact with family and friends as required. Individuals should be supported to develop and maintain meaningful participation and presence in their local community.

(p) The staff ethos should be that the needs of individuals are paramount and are not subservient to administrative convenience.

(q) All individuals have the right to and access to their personal records in line with appropriate legislation.

(r) To support individuals to access appropriate health services, including screening programmes, annual health checks and health action plans; and to promote healthy lifestyles, diet and exercise to maintain good health and wellbeing.

(s) To support unpaid carers in their role, while enabling them to maintain a life beyond their caring responsibilities.

(t) To prevent where possible inappropriate hospital admissions and unplanned hospital attendance.

(u) To assist where appropriate with timely hospital discharge.

(v) To ensure that the Mental Capacity Act and Deprivation of Liberty Safeguards are applied appropriately, and in the least restrictive way possible.

(w) Providers should ensure that they have the right number of the right staff, properly trained and recruited for their skills, characteristics and aptitudes, supervised to ensure adherence to company policies and deployed in a way which enables them to be person centred, flexible and responsive.

The length of stay should ideally be up to 6 weeks but it is recognised that there may be exceptional circumstances where the care will need to be extended. On discharge of the Service User the intermediate care MDT will work closely with the integrated care Locality MDT to ensure safe and seamless transfer of care.

The provision of both accommodation and personal care in the Intermediate Care beds is expected to include, where required, assistance with bathing, eating, mobility, dressing, using the toilet, administration of medicines and any other necessary personal care support which may reasonably be required to meet Service Users individual care needs.