

SERVICE SPECIFICATION

Service	Levels of Care (levels 2 – 4)
Commissioner Lead	
Provider Lead	
Period	

Specification Version Control			
Version	Date	Lead	Significant Changes
1	25/05/2011	AB	
2	10/07/2011	AB	Amended following consultation period
3	08/08/2011	AB	Further amendments following consultation
4	11/08/2011	AB	Amendments agreed at LOC Steering Group meeting

1. Purpose

1.1 Aims

‘Levels of Care’ is a service model that determines the most clinically suitable placement based on the provision of high quality care in settings that are most appropriate to people’s needs via an integrated approach between health and social care organisations Its specific aims are to:

- Deliver services to people who would otherwise face unnecessary prolonged hospital stays within agreed timescales.
- Maximise independence and enable service users to resume living at home safely in a time efficient manner
- Provide multi-disciplinary, seamless care closer to a person’s home, reducing avoidable hospital admission and avoiding delays in discharge and reducing avoidable nursing and residential care admissions
- Incorporate cross-professional and cross-provider working and improving health and social care outcomes
- Provide a system that is flexible enough to meet individual service user

needs, focusing on pro-active care co-ordination, supported self-care, prevention so patients achieve optimum outcomes and health education aiming to reduce relapse and hospital admissions.

- Provide improved service user experiences.
- Provide more cost effective care.
- Focus on a preventative agenda aimed at maximising independence and reducing reliance/delaying need for longer term health and social care services.

1.2 Evidence Base

The White Paper 'Our Health, Our Care, Our Say: A New Direction for Community Services' (DH 2006) describes opportunities to provide care differently, out of hospital, in communities and people's homes, where they can access safe and convenient care. Intermediate care guidance (DH 2001) and National Services Frameworks for older people and long term conditions also provide evidence for Levels of Care type service provision. These indicated a requirement for a new layer of care between primary and specialist services, which would provide integrated services to:

- ✓ Promote faster recovery from illness.
- ✓ Prevent unnecessary acute hospital admissions.
- ✓ Support timely discharge.
- ✓ Maximise independent living.

They also indicated that this type of care could:

- ✓ Be targeted at people who would otherwise face unnecessary prolonged hospital stays.
- ✓ Be provided on the basis of a comprehensive holistic assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation.
- ✓ Be designed to maximise independence and to enable individuals to remain or resume living at home.
- ✓ Involve short term interventions, typically lasting no more than 6 weeks and frequently as little as 1-2 weeks or less.
- ✓ Involve cross-professional working, within the framework of the single assessment process, a single professional record and shared protocols.

MCAP (Medical Care Appropriateness Protocols) based audits undertaken during 2010/2011 indicated that a number of patients were occupying a hospital bed when they were deemed medically fit to be discharged to a community based health/social care service.

The NHS Improvement Plan (DH 2004) places emphasis on the ability of the NHS to care for people in the community, calling for 'fewer emergency admissions which cause anxiety for patients and are a poor use of hospital resources'.

The report 'Getting the Basics Right' (DH 2007) summarised the observation of 14 projects in five healthcare communities. The aim of their work was to identify the conditions that had to be met to enable shifts in care. The factors affecting the ability to bring about shifts in care were identified as:

- Receptive organisational and policy contexts in which shifts were attempted.
- Organisational leadership and sponsorship of service improvement.
- Action to overcome cultural barriers to change and improvement.
- Sufficient time to make shifts, particularly during a period of organisational change.
- Arrangements for sustaining shifts and scaling them up, including developing business cases and specifications.

The Kings Fund (Sigh and Ham 2005) indicated that systems in which care co-ordination is a central component tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction.

'Where next for the NHS reforms?' (Kings Fund, 2011) indicated that the NHS is faced with the major challenges of using resources more efficiently and of meeting the needs of an ageing population in which chronic medical conditions are increasingly prevalent. It indicated that the key task is to implement a new model of care in which clinicians work together more closely to meet the needs of people and to co-ordinate services. This model of integrated care should focus much more on preventing ill health, supporting self care, enhancing primary care, providing care in people's homes and the community, and increasing the co-ordination between primary care teams and specialists and between health and social care.

1.3 General Overview

The Levels of Care model addresses the major challenge of using resources more efficiently whilst meeting the needs of an increasingly ageing local population in which chronic conditions are increasingly prevalent. It is a model in which professionals and clinicians from health and social care organisations work together more closely together to meet the needs of the population and to co-ordinate services. Thus moving beyond fragmentation between providers and services to effective co-ordination around the needs of the community.

There are four levels within this model namely:

Level 1: Acute Care

The aim of this level is to arrest or control an illness, injury or condition.

Level 2: Sub Acute Care

A step-up or step-down treatment which further refines a care plan whilst managing co-occurring conditions when the primary complaint has been arrested or controlled, or is stable.

Level 3: Intermediate Care (facility based)

A step-up or step down unit in a care environment with intermittent input from a range of health professionals. Will either initiate or finish a course of treatment where the frequency or complexity cannot be managed in the home or where the service user has problems with activities of daily living, including transfer, mobility and safety and which cannot be addressed by home-based support.

Level 4: Intermediate Care (home based)

A service to assess, initiate, maintain or complete a course of treatment that requires supervision but where the individual can be supported at home.

For the purposes of this specification we will be dealing with Levels 2 to 4.

1.4 Objectives

- Deliver a pathway of care across all levels to ensure seamless, risk managed care, with reduced duplication of assessment and diagnostics and enhanced communication.
- Increased integrated working between health and social care to deliver the levels of care pathway.
- Provision of an integrated, jointly appointed and singularly managed, multi-skilled community team delivering robust health and social care outcomes and high levels of service user satisfaction.
- Increase the prevention of unnecessary admissions (including readmissions) to hospital of people in crisis, who could safely be looked after elsewhere within the levels of care pathway.
- To facilitate the timely discharge of service users from any of the services within the levels of care pathway (e.g. from hospital for those who no longer

require acute medical intervention).

- Implementation of a robust system to measure the performance within the levels of care pathway, meeting commissioner performance monitoring requirements.
- Work towards developing the capability to share service user level data between health and social care.
- The levels of care pathway will be flexible enough to incorporate any future technological innovations.
- Any care planning should have, as its ultimate aim, to get people in their own home as soon as possible i.e. get people back to optimum health in order to assist them towards independent living over a short period of time.
- Implementation of a single assessment process and use of individualised care plans thus developing the capability to share data at an individual level between health and social care organisations. In developing this process the feasibility of developing an electronic care plan will be considered.
- Accurate recording for individual outcomes to show improvement in individual quality of life following involvement of the Levels of Care service
- Reduction of unnecessary handover/contacts with separate health and social care staff
- Improved support for carers to carry out their caring role effectively

1.5 Expected Outcomes

- Improved access to services throughout the levels of care pathway through the delivery of seamless care and services at the appropriate time, place and by the most appropriate professional(s).
- Enhanced level of clinical and social care outcome for individuals through implementation of seamless, risk managed levels of care pathway, reduced duplication of assessment, diagnostics and the sharing of information, facilitating the delivery of efficient and effective services.
- An increased number of people remaining in their own home and maintaining their independence
- Enhanced service user and carer experience, satisfaction and quality of life both through being healthier and spending less time in hospital; this through a process of delivering proactive approaches focussed on providing individuals with the knowledge and skills to facilitate self-care, well-being and promote independence.
- Deliver high standards relating to speed of response to identified need.
- Reduction in admissions to acute settings.
- Reduction in length of stay in acute settings through an improvement in patient throughput.

- Reduction in current levels of acute bed base.
- Reduction in the number of people being admitted to residential/nursing care from a hospital setting.
- Increase in the number of older people with mental health problems, including dementia, receiving appropriate care, reablement and support to live at home.
- Increased independence and therefore reduced allocated care hours through provision of technologies like telecare/telehealth.
- To facilitate fast track for people who wish to die at home.
- Increase of early hospital release days due to installation of minor adaptations, reduction in trip hazards and/or installation of telecare/telehealth equipment.

2. Scope

2.1 Service Description

Level 2

A step up or step down unit (ideally in a community setting) to further refine a treatment plan whilst managing co-occurring conditions when the primary complaint has been arrested, controlled or is stable.

Rehabilitation goal is to restore as much function as possible and to either discharge to home or transfer the service user to a lower level of care.

Palliative care goal is to support patient to achieve their preferred place of care and death

Diagnostics should be available onsite or easily accessible on demand.

For people who are sufficiently medical stable and therefore do not require consultant care input two or three times a week but do require skilled nursing and/or therapy input on a relatively intensive basis, and regular medical input and / or more specialist rehabilitation. This may be provided in community hospitals or in identified sub-acute wards on acute hospital sites.

Essential criteria: Service users medically stable

Service user requires medical review every 2 – 3 days

Nursing intervention at least 4 hourly

Clear pathways and protocols for stepping up or down care
Staffed to recommended levels
Clear leadership and lines of responsibility
Multi-disciplinary teams and meetings to discuss the care of the individual
Access to specialist care and advice where needed

Level 3

A step up or step down unit to initiate or finish a course of treatment where the frequency or complexity cannot be managed in the home (usually greater than 3 visits a day and/or high level therapy problems requiring equipment, resources and facilities), or where the service user has problems with activities of daily living, including transfer, mobility and safety.

Rehabilitation objective is to initiate, maintain and complete a programme of therapy so the service user can return home with maximum functional capability.

For people who no longer require skilled nursing input above the level that can be provided by a community team, but do require an ongoing period of recuperation or rehabilitation, which is not necessarily a social care need, and whose care needs and / or personal circumstances mean that they cannot yet be supported at home. These are care-led beds, with nursing and therapy input from the community team as in level 4.

Level 3 will be delivered by an integrated health and social care community team based in the community with clear links to other pathways, processes and organisations (this team will also cover Level 4).

Essential criteria: Service user requires low level of nursing input.
Care level same as level 4 but cannot be managed via home-based support.
Medical care to be provided by primary care when required.
Interventions to be provided by OT's, physiotherapists or therapist technician once or twice per day.
Health or social care needs that can be delivered by a multi-skilled team.

Level 4

Level 4 service aims to initiate, maintain or complete a course of treatment that requires supervision, but where a person can be safely supported at home. The goal being to maximise independence whilst minimising dependency on ongoing

services. Provision will be accessed through a central point and be home based. It will include a rapid response element within a maximum timescale of 2 hours, depending on the level of urgency. Service users will receive a single assessment by a trusted assessor, who will communicate effectively with all colleagues to provide a service for that individual as required. Level 4 will deliver home based care and palliative care, and provide in reach support to intermediate care beds and sub acute care.

The commissioning intention for Level 4 is to secure the provision of a comprehensive range of integrated services in the community focused on promoting self-care, rehabilitation and independent living e.g. from small therapeutic interventions to intensive support from multi-disciplinary teams.

As with Level 3 there will be an integrated health and social care community team based in the community with clear links to other pathways, processes and organisations

Essential criteria: Care level same as Level 3 but where support needs can be met in the home environment.

Individual monitoring infrequent (e.g three times a week or up to three times a day)

Staffing ratios dependent on individual service user need, and capability of the individual and their carer.

2.2 Accessibility/acceptability

The service will be provided to adults over the age of 18 and are subject to the commissioning responsibility of xxxxxxxx Commissioning Consortium.

2.3 Whole System Relationships

Levels of Care cannot work in isolation and must work with partners to deliver safe, effective and clear pathways. Partners will include:

- Primary Care
- Secondary Care
- Social Care
- Community Services
- Voluntary Sector
- Nursing Homes
- Residential Care

- Mental Health
- Hospices
- Other services as appropriate

2.4 Interdependencies

The service works in collaboration with all health and social care professional agencies through the assessment and care provision processes, from referral to and discharge from the service. There will be robust links to voluntary agencies and support groups for those concerned and their carers. The delivery of services is also dependent on good IT links between different services to allow sharing and using of information as required and to provide the necessary monitoring and outcomes data. This ensures that each individual receives the most appropriate care in order to get them back to optimum health and assisting them towards independent living.

2.5 Relevant Clinical Networks and Screening Programmes

The Levels of Care Service will be expected to provide information to national networks as appropriate. It will be expected to provide support, expert opinion and information to relevant local networks and also to keep updated on information coming out of networks either through attendance at relevant meetings or via some other agreed route..

2.6 Sub-contractors

It is not expected that sub-contracting will be required in relation to the Levels of Care provision. However should sub-contracting be required, this will be in agreement with the commissioners and the service will ensure that full and relevant information is provided.

3. Service Delivery

3.1 Service Model

The overall model is illustrated in Appendix 1.

Level 2

Level 2 will require a facility based model that can provide either step up or step

down care or direct referral. It will assist people who are medically stable in an acute setting, by providing a short term rehabilitation intervention designed to enable a timely co-ordinated discharge from a hospital-based setting. The objective will be to improve an individual's level of independence/recovery/daily functional ability to enable them to be stepped down to levels 3 or 4 or be discharged home (the palliative care pathway will result in patients achieving their preferred place of care and death). Essentially this will be achieved through refining existing treatment plans, whilst managing co-occurring conditions when the primary complaint has either been arrested, controlled or is stable.

There will be a rehabilitative element within the model i.e. to restore as much function as possible and also to transfer the individual concerned to a lower level (either 3 or 4) when it is expedient to do so.

The core elements of this level will be:

- Access to the same skill set and knowledge base as acute care (including diagnostics).
- Balanced skill mix with availability of the following staffing elements:
 - ✓ Consultant
 - ✓ GP with Special Interest in care of the elderly
 - ✓ Nursing (including nurse prescribers)
 - ✓ Links to Social Care (to assist in the achievement of discharge goals in a timely manner)
 - ✓ Therapy:
 - Occupational Therapy
 - Physiotherapy
 - Speech & Language Therapy
 - Dietetics
 - ✓ Generic Support
- Diagnostics, available on site or easily accessible on demand:
 - ✓ X-ray
 - ✓ ECG
 - ✓ Echo
- Patient Transport
- Pharmacy
- Estate that includes facilities:
 - ✓ Bedded ward(s)
 - ✓ Laundry
 - ✓ Catering
 - ✓ Portering
 - ✓ Domestic services
 - ✓ Equipment including:

- Profiling beds
- Hoists
- Piped oxygen
- Resuscitation

In addition to the core elements the team would also require access to the following areas of expertise:

- Primary Care including:
 - ✓ GPs
 - ✓ Practice Nurses
- Mental Health including:
 - ✓ Psychiatry
 - ✓ Psychology
- Community Services including:
 - ✓ Community Matrons
 - ✓ Case Management
 - ✓ Community/District Nursing leading palliative care
 - ✓ Carers Support
 - ✓ Falls Assessment
 - ✓ Social Care Assessment
- Specialisms including:
 - ✓ Tissue viability
 - ✓ Specialist Palliative Care in all settings
 - ✓ Continence management

Levels 3 and 4

The expected outcomes from levels 3 and 4 are consistent i.e. to support the transition of an individual from intermediate care to home, by offering a short period of rehabilitation then to regain sufficient physical functioning and confidence to live independently at home. Consequently there will be a requirement to develop a fully integrated health and social care community team with a single point of contact. This team would provide both step up and step down. It will be based on the working practices of the existing:

- Fast Response Team;
- Community Virtual Wards;
- Rapid Assessment Team;

- Reablement Service.

The aim of the team will be to deliver rehabilitation, reablement, intermediate care and support palliative care packages in the community in order to avoid unnecessary hospital, residential and nursing home admission and facilitate discharge by enabling people to be supported in the community.

The core elements of the integrated health and social care team would be:

- Single Point of Access
- Assessment requiring access to:
 - ✓ Nursing
 - ✓ Palliative Care
 - ✓ Occupational Therapy
 - ✓ Physiotherapy
 - ✓ Care Management
 - ✓ Telecare/telehealth
- Reablement requiring access to:
 - ✓ Social Care assessment and reablement service provision
 - ✓ Nursing
 - ✓ Occupational Therapy
 - ✓ Physiotherapy
 - ✓ Generic Practitioners
 - ✓ Equipment, including telecare (as and when required)
 - ✓ Rehabilitation facilities
 - ✓ Information about local voluntary sector and universal services

In addition to the core elements the team would also require access to the following areas of expertise:

- Primary Care including:
 - ✓ GPs
 - ✓ Practice Nurses
- Mental Health including:
 - ✓ Psychiatry
 - ✓ Psychology
 - ✓ Nursing
- Secondary Care including:
 - ✓ Geriatrics

- ✓ Dietetics
- ✓ Diagnostics
- Community Services including:
 - ✓ Community Matrons
 - ✓ Case Management
 - ✓ Community Nursing/District Nursing to lead palliative care provision in the community
 - ✓ Carers Support
 - ✓ Falls Assessment
- Specialisms including:
 - ✓ Tissue viability
 - Specialist Palliative Care in all settings .
- Voluntary Sector service provision including:
 - Home from Hospital services
 - Carers services
 - Dementia services

The responsibilities and requirements of the team will include:

- Bed management in relation to health and non health level 3 beds in the community.
- Training to provide a basic knowledge regarding the management of dementia.
- Training for generic assistants in the reablement of neurological conditions would be provided.
- Support the implementation of Telecare and Telehealth initiatives.
- Signposting to voluntary sector and universal services
- Delivery of standards of care as defined in national and locally agreed guidance.
- Making onward referral and seeking specialist advice as necessary
- Ensuring carers have sufficient support and training
- Planning an exit strategy for each individual, ensuring they and their carers understand when and why support is coming to an end and how to reconnect with services if need arises.
- Ensuring individuals are involved in decisions about their care
- Conducting satisfaction reviews and auditing of service provision on at least an annual basis
- Provide support and cover to ensure continual professional development

3.2 Care Pathways

The Levels of Care pathway will be agreed with commissioners and will indicate the meeting of the objectives highlighted in section 1.4.

3.3 Workforce

Staff will be trained to an appropriate level to carry out the required functions in order to achieve the objectives, confidently and competently. This will include:

- Safeguarding
- Dementia
- Carer awareness
- Diversity and equality
- Lasting Powers of Attorney
- DOLS
- Mental Capacity Act
- Understanding of complaints process and PALS services
- Nursing home services
- Continuing care requirements

This is not an exhaustive list but an indication of the range of activities.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The service is open to all those subject to the commissioning responsibilities of the xxxxxx Consortia and over the age of 18.

4.2 Location(s) of Service Delivery

To be determined

4.3 Days/Hours of operation

The expectation would be that this team would operate 24/7 on a flexible

basis in order to meet demand

4.4 Referral criteria & sources

It is not possible to produce a definitive list of service users or types of presenting conditions but, as a guide Levels of Care will support the outcomes identified in Section 1.5.

Those providing the Levels of Care service will ensure all individuals presenting are accepted for triage and assessment. Access will be through a single point of entry based on explicit and specific referral criteria (that has been approved by the commissioners) and promoted to referral sources in primary, secondary and community care.

Referrals will be received from a range of sources including:

- ✓ Self referral
- ✓ Primary Care
- ✓ Community services
- ✓ Acute services
- ✓ Out of Hours service
- ✓ Carer or relative (if known by the service)
- ✓ Social services
- ✓ Specialist Nursing
- ✓ Nursing/Residential homes
- ✓ Mental Health Services
- ✓ Voluntary Sector

Referrals to the various levels will be for a time limited period (based on agreement with the commissioners), mainly for the reason of avoiding unnecessary or prolonged hospital, residential or nursing home admission or to facilitate rehabilitation on a step-up or step down basis.

The key element as to whether or not an individual meets the criteria for the Levels of Care Service will be the assessed level of risk of further deterioration without prompt and/or timely intervention, or an indication that an improvement in function could be achieved thus reducing dependency on care and promoting independence. This will be determined through the triage and assessment process.

4.5 Referral route

Individuals who meet the referral criteria will be accepted via a single point of

referral

The service will, where necessary, return to the referrer any referral that does not meet the explicit and specific referral criteria and/or is not sufficiently comprehensive to determine this. The service will need to signpost if self-referral takes place.

If necessary the service will facilitate access to specialist services as an onward referral

4.6 Exclusion Criteria

Individuals who:

- Require acute care.
- Do not meet the referral criteria indicated in section 4.4
- Are under the age of 18.
- Not subject to the commissioning responsibilities of xxxxxx Commissioning Consortium.

4.7 Response time and prioritisation

All urgent referrals will be telephoned and triaged within 4 hours of receipt of referral. All routine referrals to be triaged within 1 working day.

Triage will indicate if the individual is appropriate for the Levels of Care service and indicate which level is preferred. The provision of the service will ensure that, wherever possible, prioritisation is in line with the following:

- ✓ An acute admission is avoided/early discharge is facilitated.
- ✓ Level 2 or 3 bed access is achieved if required.

4.8 Record keeping and communication

The collation of data will be in accordance to an agreed minimum data set with the commissioners.

Where required multi-disciplinary meetings will take place to discuss individual's requirements/outcomes.

5. Discharge Criteria & Planning

Discussions with the individual around discharge planning will begin at the commencement of treatment and will continue throughout the episode of care. Individual Care plans which include discharge planning will be utilised throughout treatment.

The Levels of Care service will ensure:

- Discharge arrangements take into account the needs of the individual concerned, their family and carer(s).
- A proactive approach to discharge planning to avoid delayed discharges within the service, this to include an expected date of discharge being identified once the individual enters the service.
- A robust discharge policy is in place and available to all Levels of Care staff to ensure best and consistent practice.
- On discharge information will be provided about who to contact if service is required in the future, as well as signposts to other services.

6. Self-Care and Service User and Carer Information

The Levels of Care service will ensure that:

- ✓ Self-care and self-management of an individual's condition is a key priority/outcome of the intervention.
- ✓ Relevant information will be provided as required. It will be in a format accessible for the individual concerned in order for them to gain knowledge and understanding of their condition, thus enabling them to make informed choices for care and treatment.
- ✓ Appropriate support is given to both individuals concerned and carers to facilitate and promote self/care/management.
- ✓ Promotion of user and carer involvement in the planning, delivery of care and services will be undertaken.
- ✓ Where applicable all individuals are given the opportunity to access appropriate self-management training e.g. Expert Patient programme.
- ✓ All individuals and their carers will be given clear information regarding the aims and objectives of the Levels of Care service, what they can expect to receive, discharge processes, other services they may wish to access (e.g. voluntary sector) and how to utilise the complaints process.
- ✓ Carers should have the choice to be involved with the individual's care plan and rehabilitation, with consent of the individual (or in line with the Mental Capacity Act).

The levels of care service will ensure that it actively encourages communication and engagement between themselves and key stakeholders and demonstrate that feedback from those concerned is used to inform service redesign.delivery. The minimum requirement of this should include:

- ✓ Surveys/questionnaires of those using the Levels of Care service
- ✓ Carer surveys/questionnaires
- ✓ GP survey/questionnaires
- ✓ Routine contracting/performance meetings with commissioners.

<i>7. Quality and Performance Indicators</i>	<i>Quality and Performance Indicator(s)</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of Breach</i>
HCAI Control				
Service User Experience				
Improving Service Users & Carers Experience				
Unplanned admissions				
Reducing Inequalities				
Reducing Barriers				
Improving Productivity				
Access				
Personalised Care Planning				
Outcomes				
Additional Measures for Block Contracts:-				
Staff turnover rates				

Sickness levels				
Agency and bank spend				
Contacts per FTE				

8. Activity

<i>Activity Performance Indicators</i>	<i>Threshold</i>	<i>Method of measurement</i>	<i>Consequence of breach</i>

Activity Plan

The Levels of Care service will ensure that activity data is provided to meet the agreed performance monitoring requirements as agreed with commissioners.

The service will provide activity and performance information both as a total for the whole service and also broken down by its individual components. This will in line with contract requirements as agreed with the commissioners.

9. Continual Service Improvement Plan

Future performance targets and thresholds will be agreed with commissioners and will be based on the establishment of baseline targets.

10. Prices & Costs

To be determined

10.1 Price

Provider(s) to provide a schedule of costs for each level based on this specification.

Version 4

Appendix 1: High Level Model of proposed Levels of Care Service

