Shropshire Council

Shropshire Council
Shirehall
Abbey Foregate
Shrewsbury
Shropshire SY2 6ND

Date: 18th August 2022

My Ref:
Your Ref

Dear Care Provider

EXPRESSIONS OF INTEREST

FOR BLOCK CONTRACTS FOR REABLEMENT BEDS, RESIDENTIAL, NURSING WITH AND WITHOUT DEMENTIA CARE

Shropshire Council is looking to award short term contracts for a rehabilitation and reablement community-based provision, offering expertise to re able individuals and provide a step-down provision following a period of hospital admission in a care home setting.

To support this work Shropshire Council is seeking to award block contracts, for varying bed numbers, with a range of care home providers in Shropshire. Consideration will also be given to bids in respect of care homes on Shropshire's borders, and for any homes falling into this category Shropshire Council may seek relevant information from the care home host local authority.

Service description/aims:
The service aim is to maximise the resident's capacity to become independent to enable their future needs to be met their own home. The resident's pathway after leaving a bed-based service may continue, accessing different home-based services.

- A service commissioned in a care home which has GP and therapy support which will enable people through a maximum stay of 4 weeks.
- A non-optional service for people who need reablement – much like moving to a different hospital ward
- To facilitate timely discharge from hospital (Discharge hub) the Fact-Finding Assessment will be accepted by the home initially. Following this a care plan, inclusive of multi-disciplinary input and all professionals will be developed as quickly as possible to enable safe delivery of the care and support needed, ensuring the residents rehabilitation needs are met.

- Work with therapeutic teams will be required to support each person to reach their optimal potential and dedicated senior staff will liaise with the case manager each week to ensure the Rehab beds do not hinder patient flow. This relationship is key to mutually managing any issues that arise during the contract and to support the person, our service, and the commissioners to achieving positive outcomes.
- Staff will be working in a culture of supporting people whose aim is to go home, understanding there is no scope to deviate from this message when engaging with the person or their families and working to a different set of expected outcomes.

Service model/specification:

- **28-week contract to commence on 05/09/2022 until 31/03/2023**
- **Nursing beds (with and without dementia care) to be specified in the EOI by the provider (option to flex beds as required.)**
- **Residential beds (with and without dementia care) to be specified in the EOI by the provider (option to flex beds as required).**
- **The minimum number of beds offered must be 4 beds and the maximum 6 beds**
- **Admission: 7 days a week 08.00 to 20.00.**
- **Admissions and isolation periods to be compliant with current Government guidance.**
- **Key contact/Case Manager is established to liaise with the LA/discharge hub to ensure effective and timely discharge.**
- **To ensure the capacity of the resident is maximised, other services needed to be provided to the individual in the bed-based service, two key additional services;**
    - **GP Support,**
    - **Therapy Services.**
- **The beds will require wrap around service support for physiotherapy, occupational therapy, and a designated case manager to ensure people move on to home or care environment within the accepted time frame** (These are not part of the contract. They are services contracted in/arranged by Adult Social Care/NHS jointly).

***Referrals**:*

Referrals into the reablement beds will be made via the "*Discharge Hub*". Homes will ***not*** be expected to undertake assessments of prospective service users prior to referral but will receive a Fact-Finding Assessment from the Discharge Hub.

- **Homes will be required to accept admission into the Reablement bed within 2hrs of a referral being agreed. Homes will be required to make immediate decisions regarding admitting a referral. These timescales will be expected to apply 7 days a week between the hours of 08.00 to 20.00.**

- **Following the admission, a care plan will be developed with a multi-disciplinary approach to enable safe delivery of the care and support needed and ensure the residents rehabilitation needs are met.**

***Contract**:*

Commencement date of the contract will be agreed following contract award, to include all of the beds in the contract. It is expected that referrals and admissions into the beds will be phased to reflect demand for the Service.
From the commencement date, each bed on the contract will be initiated individually, payment will only be initiated as each beds on the contract is occupied.
Price: The Price will be the "price per bed per week". The Council will pay the Price until the expiry date of the contract (to include any extension periods).
NHS Funded Nursing Care (FNC): FNC will not need to be claimed from the ICB. The contract price will be the gross price.

Please raise all clarification questions before 23/08/2022

Expressing an interest:

If you are interested in providing beds please complete the form below, giving consideration to the requirements set out in this letter, returning your expression of interest no later than **12 noon 24/08/2022.**

Bidders can express an interest in offering as many beds, as they wish as long as the care home /provider is compliant with all requirements set out above. **However, the minimum number of beds offered must be 4 beds and the maximum 6 beds**

Preference will be given to providers who have the most flexibility.

Please return the Expressions of Interest by submitting by email to Richard Warburton, Contracts Manager richard.warburton@shropshire.gov.uk

Should this procurement exercise result in a greater number of beds being offered by care homes than the Council is currently seeking to secure, expressions of interest will be considered on:

- ability to provide the beds in the near future
- home location
- most competitive price submitted and ability to offer beds at or around the current market price
- quality ratings and performance ratings

- experience of providing residential or nursing home services, working with other agencies and supporting hospital discharge.

Contract: Contracts will be for a combination of bed types that is reflective of the bids received and the Council requirements and by mutual agreement may include flexibility to change bed types. **The contracts will initially be to 31 March 2023.** The need to extend contracts will be reviewed during the final month of the contract. In any event, any placements made into the block contract will continue to be funded until the end of each Service User's period of recovery and recuperation.

Availability: Shropshire Council would prefer beds to be available in the very near future,but will liaise with successful providers regarding exact dates.

Expressions of interest cannot be accepted if they are received by post or facsimilie.

If you are unsure of any of the requirements of the expression of interest and require further clarifications, please make contact via email to richard.warburton@shropshire.gov.uk

Yours sincerely

Richard Warburton

Richard Warburton
Contracts Manager
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SHROPSHIRE COUNCIL

EXPRESSION OF INTEREST IN BLOCK CONTRACTS FOR REABLEMENT BEDS

Yes, I am interested in providing block contract beds for beds in Shropshire. The Price is detailed below. I agree that:

- I understand that any award of contract will be subject to the above; and confirmation of GP support to service users receiving the Service.
- I will sign the Council's block bed contract for Reablement Beds (*the contract will be based on the Councils Pre Placement Agreement for Residential and Nursing Care combined with the indicative specification for Reablement Beds*).
- I have read the indicative specification below for Reablement Beds and understand the needs of the services required to support hospital discharge, and provide a recovery and recuperation service.
- The home named below has experience working with external agencies in particular the NHS
- FNC cannot be claimed from the CCG in addition to the contract price.
- I will be able to process referrals and accept admissions into the home 7 days a week between the hours of 08.00 to 20.00 via the "*Discharge Hub"*

Bed type	Number of Reablement block beds I wish to offer is	Proposed price per bed per week £ (NB FNC not claimable)	Name of the Home at which the beds will be provided	Experience of accepting hospital discharges (Yes/No)	Date these beds will be available for use from
Residential					
Residential with dementia care					
Nursing					
Nursing with dementia care					

Name of contact and contact details:	
Role of the contact:	
Name/Legal Entity of the provider:	
Date of submission of expression of interest:	

Indicative Specification: Service Delivery & Standards

COVID-19 DESIGNATED SETTINGS BEDS TO SUPPORT HOSPITAL DISCHARGE

The Specification sets out the Service for beds providing care for Reablement / other conditions for which their episode of acute care is complete, plus the core residential/nursing service, and standards of delivery across all elements of the Service.

SCHEDULE 1: SERVICE DESCRIPTION: REABLEMENT BED SERVICE

The Service must provide a care home based short term service that focuses on recovery and recuperation in support of discharge from hospital for Service Users, for which their episode of acute care is complete.

1.0 REABLEMENT BED SERVICE AIMS

1.1 The Council and the Service Provider agree that the aims of this Service are to:

1.1.1 support timely discharge from Hospital (SATH) to enable Service Users to move on to a more appropriate location to meet their future needs.

1.1.2 provide a service which helps Service Users whose episode of acute care is complete, to recover and recuperate.

1.1.3 provide a competent, skilled workforce, dedicated to the service, who will support and encourage Service Users to achieve their optimum functional independence,

1.1.4 provide a supportive care environment whereby recovery and recuperation can allow for an assessment of ongoing care needs.

1.1.5 build on current collaborative working with Shropshire health and social care colleagues to meet agreed milestones and goals.

1.1.6 secure and maintain compliance with CQC's CQC Infection Prevention Control (IPC) Protocol https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes

2.0 THE RECOVERY NURSING BED SERVICE TO BE PROVIDED BY THE SERVICE PROVIDER

2.1 The Council and the Service Provider agree that in the provision of the Service the Service Provider will:

2.1.1 have available **XXXXX** dedicated beds at the Home for the provision of the Service and are able to accept admissions 7 days a week between 8am to 8pm The **XXXX** beds will operate as general nursing/residential/nursing with dementia/residential with dementia recovery beds.

2.1.2 respond to the varied needs of different Service Users, giving regard to needs arising from; acute illness (that can be managed without the requirement for hospital care), reduction in ability to live independently, frailty and nursing needs.

2.1.3 be expected to provide person centred support and follow the guidance of the Equality Act 2010 in taking into account wherever possible ethnicity, culture, beliefs, special needs and gender specific concerns when meeting need and care planning.

2.1.4 communicate with Service Users, families and carers that the Service Users stay at the placement is short term whilst they are supported with ongoing recovery and assessments. It is fundamental that the Service Provider explains to Service Users and their family / carers that they will not be able to remain in the bed long term and that there is an expectation that wherever possible individuals will return to their own homes. If in exceptional circumstances, the individual is unable to return to their previous arrangements the Service Provider must ensure that all decisions will be explored fully in partnership with the Discharge Hub/appropriate Case Manager.

2.1.5 provide a therapeutic environment for assessment to inform long term care decisions to be made if required.

2.1.6 facilitate access to the Service Users by the Home's GP Support and appropriate therapists as and when required

2.1.7 facilitate and work towards discharging Service Users to their own homes.

2.1.8 ensure that each Service User has individual Care Planning Documentation.

2.1.9 ensure that all Service Users' progress will be proactively managed along an agreed care pathway, recorded in the Service Users Care Planning Documentation, with records of accountability and governance made for agreed actions and reviews,

3.0 MEDICAL CARE

3.1 The Service Provider will ensure that:

3.1.1 once a Service User has been admitted to the Home medical cover is provided by the Home's GP Support.

3.1.2 the Home seeks support or guidance from the Home's GP Support whenever it is felt that the Service User's condition requires General Practitioner input, or where General Practitioner input could contribute to Service Users timely discharge from the home.

3.1.3 The Home's GP Support should cover out of hours GP services.

3.1.4 the Home contacts the Discharge Hub/appropriate Case Manager should a Service User have a rapidly deteriorating condition.

3.1.5 whilst it is acknowledged that a senior medical professional, for example a GP will sign off ReSPECT documentation, the Home will assist with information gathering and discussions with family and the Service User with regard to anticipated future emergencies in which the Service User no longer has the capacity to make or express choices

3.1.6 the Service is supported by a Covid-19 Clinical Lead

4.0 MEDICATION

4.1 The Service Provider will ensure that:

4.1.1 it has policies and procedures in place for the receipt, recording, storage, handling, administration and disposal of medicines in accordance with:

- The Handling of Medicines in Social Care Settings by The Royal Pharmaceutical Society of Great Britain 2007 or subsequent revisions; and
- Professional advice documents from registration authorities and Care Standards, including The Administration of Medicines in Care Homes, Medicine Administration Records (MAR) In Care Homes and Domiciliary Care, and the Safe Management of Controlled Drugs in Care Homes or subsequent revisions.

4.1.2 Staff understand that policies and procedures listed above and adhere to them

4.1.3 its policy for medicines administration will include procedures to ensure that Service Users are able to take responsibility for their own medication if they wish, within a risk management framework and the Home's policies and procedures will protect Service Users in doing so.

4.1.4 all changes to prescribed medication are clearly documented as part of the discharge information provided to their Normal GP and, where the Service User is in receipt of formal care their care agency or the care home at which they usually reside.

4.1.5 the information relating to medicines sent from GP practices or other care settings is accurately checked, before it is recorded, to ensure that it relates to the Service User for which the medicines information has been sought.

4.1.6 all known allergies, including food intolerances, must be noted appropriately and prominently for each Service, and be included in the discharge information to person(s) who provide informal care, their Normal GP and, where the Service User

is in receipt of formal care, their care agency or the care home at which they usually reside.

5.0 REFERRALS, ADMISSION INTO THE SERVICE, AND RESPONSE TIMES & ISOLATION

5.1 The Discharge Hub will make referrals into the Service. A flow chart defining the referral process will be shared with the Service Provider after commencement of the Agreement and will form part of this Agreement. The Council and the Service Provider have agreed that the Service is for Service Users who:

5.1.1 need a place to recover from the impact and consequences of an acute illness. This may include Service Users with a cognitive impairment.

5.1.2 with regard to the hospital discharge, are an adult, in hospital, who have completed their acute episode of care but are unable to return home in the short term , or to their usual place of residence unsupported. This may include Service Users that may have a cognitive impairment and need specialist support and/or exhibit altered behaviour.

5.1.3 may be frail and where the Service is in a Nursing Home could require access to 24 hour nursing care.

5.1.4 are likely to be too fatigued to go home and need a period of wrap round care and/or may have a problem with their home environment, or for whom there has been a problem securing high capacity domiciliary care in the Service User's locality

5.1.5 may need a period of isolation within the home immediately following admission.

5.2 All referrals into the Service will be made direct from the Discharge Hub and an FFA will be provided. Where appropriate, referral paperwork will also give regard to Service Users who lack capacity.

5.3 The Service Provider is expected to accept all referrals into beds in the Service on the basis of a "trusted assessment" of the Service User (from the Independent Assessors for Care Homes) as being appropriate and eligible for the Service. For the avoidance of doubt there will be no requirement by the Service Provider to visit the potential Service User in Hospital or in their own home, to undertake an assessment, before accepting the referral.

5.4 At the Commencement Date of the Agreement the Service Provider will provide details of their named point of contact for referral of potential Service Users. This named individual(s) will be at the Home, available and responsible for receiving Service User referrals and accepting admissions 7 days a week between 8am to 8pm.

5.5 The Service Provider will immediately (no later than the same day) notify the Council once the Service Provider becomes aware that a bed within the service is to become vacant.

5.6 The Service Provider shall immediately (no later than the next day) notify the Council if a bed in the Service becomes vacant at short notice.

5.7 When beds within the Service are available, or expected to become available, the Service Provider will make a decision on accepting a referral on immediate receipt of the referral.

5.8 When beds within the Service are available the Service Provider will arrange for planned transfer of the identified Service User within a maximum of 2 hours of making a decision to accept the referral.

5.9 If the Service Provider fails to admit an agreed referral within 2 hours or rejects an appropriate referral from the Discharge Hub and as a result beds in the Service are not occupied the Council may reduce the amount payable for that bed under this Agreement

5.10 Giving regard to the requirements of the information provided by the Discharge Hub relating to the *Clinical Pathway for all hospital discharges*, where care is provided to a Service User in Isolation. Isolation should be arranged in accordance with all relevant Government Guidance.

6. STAFFING / SKILL MIX AND COMPETENCIES

6.1 The Staff will be recruited; trained, supervised and deployed, and have the experience and qualifications, as set out in Schedule 3 Paragraph 4 (Staffing). Staff will be dedicated to delivering the service and the organisation of their work and ways of working will incorporate all Government guidance and good practice relating to safe working in care homes.

6.2 The Service Provider and the Council have agreed:

6.2.1 all Service Users transferred to the Home will be adults, some will be elderly and some will have more complex issues than others. The Service Provider will provide nursing (where the Service is in a Nursing Home) and care Staff cover at all times to respond to Service User who have the highest level of need, which may include Service Users with cognitive impairment.

6.2.2 the Service Provider must ensure that the team of Staff deployed within the Home to deliver the Service have the skill, training and qualification mix to respond to the fluctuating dependency levels of different Service Users

6.2.3 the Service Provider will ensure that there is 24 hour nurse (where the Service is in a Nursing Home) and care support dedicated to the Service that has the competency and experience to support the recovery and recuperation focus of the Service Users in the Reablement Beds.

6.2.4 the Service Provider will ensure that staffing levels relating to the Service at the Home will, at all times, reflect the needs of individual Service Users. The Service Provider will have clear and transparent processes for assessing and determining the staffing levels and roles required to provide the Service.

6.2.5 The Home will cohort staff groups around Service Users and other Covid positive residents at the home ,to ensure risks of Covid-19 transmission are reduced.

6.2.6 Where the Service is in a Nursing Home the Service Provider will be mindful of the need to ensure the training and competency of nursing Staff, and will implement an action plan to address any gaps.

6.2.7 The Service Provider will ensure that Staff supporting any Service Users with dementia care needs have appropriate training, expertise and experience. The Service Provider and Staff will give particular regard to understanding how Service Users with dementia care needs are affecting by Covid-19 in delivering the Service.

6.2.8 Service Users will receive a high quality Service that reflects outcome based care and support in a safe and supportive staffing environment using evidence based nursing and/or care practices which meet all professional care standards.

7.0 TRANSPORT FROM HOSPITAL

7.1 Service Users being discharged from hospital to the Service will be transported by appropriate transport dependent on the needs of the Service User.

8.0 DISCHARGE FROM THE SERVICE

8.1 The Service Provider will ensure that each Service User will be reviewed and assessed for a planned discharge if:-

8.1.1 they are assessed to have met the recovery and recuperation goals set out in the Care Planning Documentation

8.1.3 the ongoing needs of the Service User can be met at home with or without ongoing community health and social care support.

8.1.4 a transfer to alternative care is required to meet specific identified nursing or care needs; or

8.1.5 long term care needs are identified that are more appropriate to provide in another environment.

8.2 Planned discharge will be facilitated by the Discharge Hub/appropriate Case Manager in liaison with the Service Provider. Where ongoing care or support is needed the discharge can only be facilitated following approval of required funding by the relevant Council Social Work team.

8.3 Where appropriate the Home will support the Discharge Hub/appropriate Case Manager with communications to the Service User and their family with regard to their need to contribute to the cost of any ongoing care arrangements.

8.4 When arranging and facilitating discharge from the Home the Parties will give regard to the advice regarding isolation and testing within the relevant Government guidance if required.

9.0 RECOVERY NURSING BEDS SERVICE OUTCOMES AND REPORTING

9.1 The Discharge Hub/appropriate Case Manager may require reports on the progress of the Service. If reporting is needed the requirements will be developed by liaison between the Parties following commencement of the Agreement and will form part of this Agreement.

9.2 The Parties acknowledge that with regard to any reports on the progress of the Service as may be required in accordance with 9.1 the information may sometimes be dependent upon action or data required from the Discharge Hub or Hospital and in these circumstances the Provider will not be held responsible for particular data which it is unable to provide.

9.3 The Service Provider will immediately notify the Discharge Hub in Writing and by phone of any outbreak of infections or operational failures that will impact on capacity of/access to the Service.

10.0 INFECTION CONTROL

10.1 The Service Provider will ensure that it complies with the Registration Body guidelines and any associated or recommended code of practise or guidance regarding infection control, in particular the Department of Health Code of Practice on the prevention and control of infections (or successor guidance), and all additional local or national guidance relating specifically to infection protection control reference Covid-19. The Service Provider will ensure the requirements in 10.2 are reviewed and augmented to reflect all government guidance, giving particular consideration to PPE use.

10.2 With regard to infection control within the Home the Service Provider will ensure that

- infection control management is an integral part of the overall management of the Home
- infection control guidelines are available at the Home and Staff are trained to follow them. The Home has a robust Infection Protection Control policy in place.
- a protocol is available highlighting basic principles of risk assessment in relation to microbiological hazards
- cleaning schedules are available covering all equipment and the environment and laundry to ensure good standards of general hygiene are maintained throughout the Home
- correct facilities are available to enable Staff, Service Users and visitors to decontaminate their hands appropriately
- clinical care guidelines and guidelines on decontamination of equipment reflect current

evidence based infection control guidelines

- facilities are available at the Home to manage waste and dirty linen in accordance with the legal and infection control requirements
- it can produce evidence of planned and regularly updated training for all Staff in infection control
- the correct, disposable personal protective equipment (PPE) is provided and used by Staff, and appropriate stocks and supplies of PPE are maintained.
- reasonable access is allowed to independent professionals to carry out an infection control audit or similar checks of the Home and the Home acts upon the findings and recommendations of the audit.
- the home has and operates to a policy for the safe handling and disposal of sharps
- the home undertakes immunisations risk assessments of all staff and accurate immunisation records are kept

12.0 TESTING

- The Provider will be expected to comply with Government, Council or local NHS requirements relating to testing for Covid-19.