SERVICE SPECIFICATION ON TRANSITIONAL CARE AND SUPPORT CENTRE FOR TETRAPLEGIC PATIENTS AT HENG ON ESTATE, MA ON SHAN, NEW TERRITORIES

PURPOSE

1. The Social Welfare Department (SWD) invites, through this Service Specification, non-governmental organizations (NGOs) operating subvented rehabilitation services for people with disabilities to submit an application for the operation of the Transitional Care and Support Centre for Tetraplegic Patients (TCSC) located at G/F, Heng Yat House, Heng On Estate, Ma On Shan, New Territories. This is a time-defined project of five years and the target commencement date for the service is in the third quarter of 2007-08. This service specification states the requirements and provisions for the operation of the centre.

BACKGROUND INFORMATION

2. It is a tremendous lifelong challenge for tetraplegic patients to come to terms with their severe disabilities, especially when the disabilities are acquired ones. They have to go through a long process to adjust, psychologically and physically, to the loss of abilities and adapt to neurological or functional deficits before they can develop their residual abilities and lead a normal living. The impact of disabilities becomes apparent especially upon the patients' discharge from acute/rehabilitation hospitals. It may affect family or social relationship when the persons attempt to resume self-care activities and restore family functioning. They will need much support clinically, socially and psychologically in order to cope with the transitional period while maintaining living in the community and achieving ultimate rehabilitation. To address to the transitional training and care needs of the tetraplegic patients as well as to support their family members/caregivers, funding from the Hong Kong Jockey Club Charities Trust (HKJCCT) under the Chief Executive Community Project List 2005 has been secured to set up a special transitional care and support centre for tetraplegic patients. The centre was one of the government's new initiatives in the Chief Executive's Policy Address 2005-06.

DEFINITION OF TERMS

3. The following are terms used in this Service Specification (the Specification)-

Service Users	Discharged patients suffering from spinal cord injury, neuro-muscular disease or severe spastic resulting in tetraplegia and are in need of continuous rehabilitation training for a defined period of time. If vacancies are available, severe paraplegic patients may also be target service users.
Individual Training and Support Plan (ITSP)	An organized approach to identify a service user's care, training and support needs, to develop strategies to meet those needs, and to review the effectiveness of the strategies used.
Operator	The Non-governmental Organization (NGO) which is commissioned by the Director of Social Welfare to provide the services detailed in this Specification.

Words in singular construe the same meaning as if they were in the plural form.
Words in capital construe the same meaning as if they were in small letters.

OBJECTIVES

4. The TCSC aims at providing time-defined and goal-oriented community-based rehabilitation programme to tetraplegic patients with a view to improving their physical, cognitive, communicative, behavioural, psychological and social functioning in a non-medical setting. It also serves to strengthen the training and support for the family members/caregivers of tetraplegic patients to enhance their caring capacities. Specific objectives of the TCSC are -

(a) to provide continual rehabilitation services to tetraplegic patients so as to help them achieve optimum level of recovery and functioning after their discharge from formal medical rehabilitation settings;

(b) to assist tetraplegic patients to obtain or 'polish off' the physical and social skills needed to lead a less dependent or independent living at home and to resume their social roles as far as possible;

(c) to smoothen the adjustment process of tetraplegic patients during the transitional period so as to assist them to overcome adjustment problems, including psychosocial and emotional issues, relationship, sexuality, parenting and stress management, etc.;

(d) to promote community care and enhance the quality of life of tetraplegic patients; and

(e) to empower the families in providing long-term care to the tetraplegic patients through providing skills training and tangible support.

SCOPE OF SERVICES

5. TCSC will provide comprehensive psychosocial, health care and support services, including but not limited to rehabilitation training, counselling service, peer support group, community re-entry training and orientation programme, aids and equipment for independent living, patient education and provision of relevant information, referral for social and community services, social and recreational programmes, day and residential respite care and home environment assessment and modifications. It aims to offer a flexible, client-centred rehabilitation service that allows patients to continue to work towards their rehabilitation goals in a supportive environment upon discharge from hospitals/medical rehabilitation centres.

6. The Operator is required to meet the individual and holistic needs of service users by providing a well-planned and co-ordinated range of services listed in Paragraph 5 above, and facilitating their social rehabilitation. The range of services should be incorporated in a detailed service plan in a proposal covering the following core programmes:

Transitional Residential Service

Transitional residential service is provided to individual patient with a view to facilitating his/her social re-integration and social re-adjustment. The programme aims at providing a supportive living environment for tetraplegic patients to develop their skills and competence which will eventually facilitate them to live more independently in the community with the support and care of their families. Training conducted includes consolidation of physical skills, training on activities of daily living, familiarization of community access,

enhancing personal care, work and pre-work skills training, etc.

Ambulatory Day Training Programme

For tetraplegic patients who do not require transitional accommodation, ambulatory day training programme consisting day rehabilitation training is provided with a view to facilitating the re-integration process and providing continual training. Training programmes can be similar to those in the transitional residential service.

Supportive Service Programmes

Supportive service programmes are provided to tetraplegic patients and their family members/caregivers to enhance the coping capacities of the service users and the caring capacities of their family members/caregivers while relieving their care burden. Supportive services include day and residential respite, counselling service, social programmes, peer support groups, selection and purchasing of rehabilitation equipment, home assessment and modifications, leisure and recreational activities, etc.

7. The Operator should work in close collaboration and co-ordination with other helping agents, in particular, the Spinal Cord Injury Rehabilitation Teams of Hospital Authority (HA), public hospitals and specialist clinics, as well as the operators of various community-based rehabilitation services. Services should be arranged in a convenient and user-friendly manner to service users and their family members/caregivers. The Operator should be ready to deliver round-the-clock services all through the year.

PREMISES, FURNITURE AND EQUIPMENT

8. TCSC with a total internal floor area of 832m^2 is located at G/F of Heng Yat House, Heng On Estate, Ma On Shan, New Territories. The location map and layout plan of the premises are provided at ***Annexes 1 and 2***. The Government will hand over the existing premises "bare-shelled", together with any as-constructed elements and installed equipment (including existing builders' works and fire services systems), to the Operator for subsequent fitting-out of the premises. SWD will, according to the concerned standards, supply the premises with fittings, fixtures, furniture and equipment by means of grant from the HKJCCT for these purposes.

9. The Operator is responsible for the fitting-out work of the premises to fulfill

statutory requirements and technical schedules standards approved by a Steering Committee specially set up for this project. HKJCCT grant caped at $9.92 millions for fitting-out works (including Approved Person consultancy fees and contingency) and the purchase of furniture and equipment (including two 16-seater vans with tail lifts) has been approved for this project. A Steering Committee chaired by the Assistant Director of Social Welfare (Rehabilitation and Medical Social Services) will steer the commissioning and monitoring of the whole project including the fitting-out works. The Operator is required to submit a detailed layout design and a proposed furniture and equipment list for the endorsement of the Steering Committee. SWD has prepared a furniture and equipment list, based on which the grant is calculated. It can be provided for Operator's reference upon request. The Operator has to observe the conditions of the grants mentioned in the approval letters and procedures and requirements set out by HKJCCT.

10. The Operator should form a project co-ordinating committee to oversee the project. The Operator is required to submit to the Steering Committee a cash-flow projection and a work plan. He should also submit details of a works programme for implementing the fitting-out works and a plan for orchestrating the implementation of the services for monitoring by SWD staff in order that the whole TCSC can commence services on schedule.

11. The Operator must maintain the premises, furniture, and equipment in a condition that will provide a safe physical environment free from obstruction and fire risk for the protection of service users, staff and visitors.

12. As part of the co-ordination and interfacing strategies promoting community-based rehabilitation, the Operator should develop a public relations strategy to inform neighbours of the TCSC and its services in order to maintain a good relationship with them.

TARGET SERVICE USERS, CAPACITY AND DURATION OF SERVICE

13. The specific target clients, capacity and duration of service for different programmes are set as below -

<table>
<tr><th>Service Component</th><th>No. of Places</th><th>Target Group</th><th>Maximum Duration</th></tr>
<tr><td>Transitional Residential Service</td><td>20</td><td rowspan="2">• Discharged patients suffering from spinal cord injury, neuro-muscular disease or severe spastic resulting in tetraplegia
• With vacancies available, severe paraplegic patients may also be target service users</td><td rowspan="2">• Not more than 12 months (Extension of service subject to review)
• Case to be reviewed at a three-month interval</td></tr>
<tr><td>Ambulatory Day Training Programme</td><td>20</td></tr>
<tr><td>Supportive Service Programme</td><td>NA</td><td>▪ Tetraplegic patients living at home in the community with their family members/caregivers</td><td>• For residential respite care, normally not more than 30 days per year</td></tr>
</table>

14. To ensure efficient turning-over of cases, every applicant and their family are required to sign a service contract with the TCSC. Moreover, referrers are expected to explain the objectives of the programmes in details and to provide follow-up support in formulating the discharge plan for their clients after admission into the TCSC.

15. SWD reserves the right to determine the placement of special or marginal cases according to individual case merit.

ENTRY AND EXIT

16. The Operator is required to set up a Co-ordinating Committee with the participation of SWD representative and HA's concerned medical and/or allied health professionals to develop a standardized service protocol, a referral system and a communication mechanism. Referrals of target users are accepted only from the professional staff of hospital. It should be included in the referral a rehabilitation plan for service user as well as their acceptance of time-defined training in TCSC. Extension of service after the completion of the agreed time-defined training programme should be carefully reassessed and recommended by the centre. To optimize the utilization of resources and reduce the unnecessary waiting time, the Operator should keep the processing time as short as possible and avoid double assessment. For the supporting service for family members/caregivers, the Operator may accept direct applications from

service users.

17. The Operator is required to have a clear operational manual and protocol for handling entry and exit of service users. In normal situation, service users may exit from the service for the following reasons -

(a) having completed the original training programme;

(b) having achieved improvement or sustained deterioration to an extent that alternative service, agreed by the referrers, is deemed more suitable;

(c) choosing to leave for whatever reasons;

(d) being hospitalized for a period more than three months without a specific discharge plan; or

(e) being admitted into a residential institution for long-term placement.

18. Proper discharge plan should be developed well in advance of the discharge date and the reasons for discharge should be documented in the individual case file. Referral or notification has to be made with other appropriate service units and concerned parties.

IMPLEMENTATION SCHEDULE

19. The implementation schedule is as follow -

Date	Task
25 January 2007	Invitation of proposals to NGOs
9 March 2007	Closing of submission of proposals
March 2007	Vetting of proposals
April 2007	Announcement of results
April 2007	The Operator to approach/ engage AP to proceed with fitting-out related works
September 2007	Completion of fitting-out works
October 2007	Commencement of service

ASSESSMENT OF APPLICATION

20. A vetting committee will be set up by SWD to assess the proposals. The assessment will be based on the quality aspects of the proposals including operation of the service and programme design, management and clinical support, co-ordination and interfacing strategies, implementation plan and mechanism for the project work, the design innovation aspects of the submitted layout plan, value-added proposals, related rehabilitation knowledge and experience, and other merits of the proposals. Details of information to be included in the proposal are at ***Annex 3***. Applicants may be invited to present their proposals to the Vetting Committee if needed.

FEE CHARGING

21. The Operator will collect the fees from service users in accordance with the appropriate fee level announced by SWD. For reference, the fees payable by service users of respective service types are proposed as follows-

Service	Fee Level
Transitional Residential Service	• $1,813 per month
Ambulatory Day Training Programme	• $60 per session
Residential Respite Care Service	• $80 per night
Transportation fee	• $10 per trip

22. The fee level is subject to revision upon further announcement from SWD. Fee waiving and reduction system should be designed for service users who have financial difficulty. Where appropriate, service users should be referred to appropriate agencies such as social security field units of SWD, medical social service units or integrated family services centres for assistance. Should the Operator wish to introduce new fees and charges for value-added service in respect of the services governed by the service agreement for which funding is provided, it must ensure that the proposed new fees and charges do not affect the services, are not detrimental to the interest of users and have obtained SWD's prior approval.

FUNDING

23. A total sum of $39.69 millions ($33.92 millions for the Personal Emolument and

$5.77 millions for Other Charges) will be released to the selected Operator quarterly to deliver the service within the whole project period of five years. The funding has taken into account personal emoluments, including provident fund for employing qualified professionals and supporting staff, all other charges for service operation, rent and rates and fees paid by service users. The use of designated sum for Personal Emolument and for Other Charges is not transferable. The approved scope and budget have to be strictly adhered to. Any deviations or major changes should not be implemented without prior approval of SWD and HKJCCT. Any liabilities or financial implication arising from the project beyond the approved funding will not be accepted. The Operator should take special care not to incorporate the funding allocated from HKJCCT with lump sum grant from SWD or other sources, if any, of the agency. As such, the amount received from the HKJCCT should be shown in the audited accounts of the Operator as a donation from HKJCCT. Any surplus from the project should be returned to HKJCCT after the termination of the project or at the end of service agreement.

PAYMENT ARRANGEMENT

24. Upon approval of the application and signing of a service agreement with SWD, payment will be made by reimbursement. The Operator is responsible for operating an effective and sound financial management system, including budget planning, projection, accounting, internal control system and auditing. It should maintain books and records and supporting documents on income and expenditure relating to the project and make them available for inspection by the Government representative. Payment requests on the capital cost will be processed upon completion and submission of the claim fulfilling the procedures as required by HKJCCT. Regarding recurrent operating costs, the fund will be reimbursed on a quarterly basis upon production of the claim for the reimbursement sum with supporting documents.

CRISIS MANAGEMET AND CONTINGENCY PLAN

25. The Operator must develop operational guidelines for crisis management as well as a contingency plan to specify strategies for the continuation of service. It should ensure that the contingency plan can be activated at all time when the TCSC encounter difficulties in providing the services as stipulated in this Specification. SWD should be informed as soon as possible when the contingency plan is activated and alternative mode of service is provided.

26. Any back-up service provided must meet all requirements of this Specification. In this regard, no additional allowance or compensation in any form will be payable by HKJCCT nor SWD in implementing the contingency plan.

TRANSITIONAL ARRANGEMENT

27. Upon expiry of the Agreement and in the event that a subsequent agreement is entered into with a new operator, the Operator should co-operate with SWD to ensure proper transfer of service to the succeeding operator.

PERFORMANCE STANDARDS

Outputs/Outcomes

28. The Operator is required to achieve the following minimum output and outcome requirements :

(a) Transitional Residential Service

Output Standard	Output Indicator	Agreed Level
1	Average enrolment rate in a year	90%
2	Rate of progress review completed within three months	100%
3	Rate of achieving individual training and support plan in a year	95%

(b) Ambulatory Day Training Programme

Output Standard	Output Indicator	Agreed Level
4	Total number of attendances in a year	4,600
5	Rate of progress review completed within three months	100%
6	Rate of achieving individual training and support plan in a year	95%

(c) Occupational Therapy/Physiotherapy Services

Output Standard	Output Indicator	Agreed Level
7	Total number of assessments, individual/group treatment sessions delivered by therapists in a year	2,000

(d) Social Work Services

Output Standard	Output Indicator	Agreed Level
8	Total number of counseling hours for service users and their families rendered by registered social workers in a year	1,800
9	Total number of support group sessions organized for service users and their family members in a year	320

(e) Other Supportive Services

Output Standard	Output Indicator	Agreed Level
10	Number of sessions providing training programmes /educational courses/ workshops for caregivers within a year	30
11	Number of sessions providing staff training programmes / workshops / seminars within a year	3

(f) Users satisfaction

Outcome Standard	Outcome Indicator	Agreed Level
12	Rate of service users being satisfied with the overall services/programmes delivered to them within one year	80%
13	Rate of caregivers being satisfied with the overall services/programmes delivered to them within one year	80%

29. The Operator is requested to indicate additional output/outcome measures and the level of attainment they expect to achieve in their proposals, in particular **objective/measurable outcome indicators showing the effectiveness of the model/ service in enabling service users to improve their functional status and to stay in the community without using residential service.** The pledged additional output/outcome measures and level of attainment will form an integral part of the Service Agreement.

Essential Service Requirements

30. The Operator is required to comply with the Essential Service Requirements (ESRs) as follows:

(a) Staff on shift duty to provide 24-hour service for residential services;

(b) Provide regular meals each day with varied food;

(c) All services comply with the advice from the concerned Steering Committee;

(d) Registered social workers, qualified nurses, and professional therapists, e.g. physiotherapist/ occupational therapist being the essential staff for the service;

(e) Operating hours for day services are from Monday to Friday, from 8:00 am to 6:00 pm and 8:00 am to 1:00pm on Saturday.

CONTROL MECHANISM

31. The Steering Committee with designated members invited by SWD would steer the direction of TCSC. The Operator is required to join in the Committee.

32. The Operator is required to comply with the requirements as laid down in this Specification, the service agreement, as well as the Operator's proposal and supplementary information, if any, as agreed with SWD/HKJCCT.

33 Where there is any change to the performance standards within the agreement period, SWD/HKJCCT will seek mutual agreement with the Operator and the Operator will be required to achieve new requirements in accordance with the agreed implementation schedule.

34 SWD reserves the right to apply the following monitoring methods -

(a) announced and unannounced visits at periodic intervals to examine in detail the performance of the Operator, such as actual achievement of outputs/outcomes, compliance with the ESRs, service quality and standard achieved or not achieved, area of concern/complaint and outcome; and

(b) user satisfaction survey as and when necessary.

35 The Operator is required to submit quarterly report to HKJCCT via SWD to provide statistical returns on the output requirements and those additional/new items pledged by the Operator, and other relevant information as required in a prescribed format and time frame. This form may be revised to incorporate changes in requirements as advised by the HKCJCT and the Steering Committee.

36. The Operator is also required to submit to HKJCCT via SWD an annual financial report and statements audited by a certified accountant or a public accountant registered under the Professional Accountants Ordinance (Cap 50).

37. A mid-term evaluation on the effectiveness of the programme and the operational model would be conducted after 30 months' operation while the final evaluation on the cost effectiveness and demand for this service would be carried out by end of fifth year's operation.

38. SWD reserves the right to suspend or terminate the agreement with the Operator before the expiry date should SWD find the Operator unable to deliver the agreed level of service, or the continuation of service by the Operator would put the service users or public interest in jeopardy, in accordance with the evidence collected by

the SWD and/or HKJCCT.

.

~ END~

Rehabilitation and Medical Social Services
Social Welfare Department
January 2007