NHS
Somerset
Clinical Commissioning Group

Service Specification No.	11X-39
Service	East Mendip Discharge Liaison Service
Commissioner Lead	As per the Particulars of the NHS Standard Contract
Provider Lead	As per the Particulars of the NHS Standard Contract
Period	01 April 2019 – 31 March 2021
Date of Review	September 2019

1. Population Needs

National/local context and evidence base

1.1 Discharge liaison is the process of planning and expediting the discharge from hospital of service users who have complex needs, including continuing health care, end of life and long term conditions and means that health care services outside hospital need to be co-ordinated to ensure the service user receives the care they need and that the discharge from hospital is not delayed.

1.2 The process of assessment and decision making should be service user-centered, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process.

1.3 A well-managed discharge benefits not only service users and their families or carers, but also health care professionals. It prevents delayed discharges and inappropriate readmissions, ensuring the cost-effective use of beds. Ideally, discharge planning should start before or on admission to ensure the timely provision of appropriate services. The aim is to assess, plan, coordinate and evaluate service user-focused, evidence-based and cost-effective care for service users leaving the hospital.

1.4 At present there is no specific, nationally endorsed, evidence-base for the provision of this service. However it will be provided in line with relevant guidelines and standards.

1.5 Following evaluation of a pilot service, it was identified that service users registered with a Somerset GP practice were remaining within the Royal United Hospital Bath NHS Foundation Trust (RUH) longer than service users supported by on-site in reach discharge services commissioned by other local CCGs.

1.6 This service formalises the current service provision, recognising the benefits of providing on-site discharge liaison support to the RUH for Somerset service users, in collaboration with existing in-reach services

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- Service users are transferred between healthcare settings in an informed, seamless and coordinated manner
- The service will respond within agreed response times
- Service users and their carers are kept fully informed of progress and notified of changes to agreed plans
- The service user's needs, preferences and circumstances are considered and responded to
- The service user will consider they have been listened to and treated with respect

3. Scope

Aims and objectives of service

3.1 This in-reach and on-site Discharge Liaison Service ("The Service") provided at the Royal United Hospitals Bath NHS Foundation Trust (RUH) aims to provide a service to service-users registered with a Somerset GP practice and which works in collaboration with any existing in-reach services to:

- expedite safe early discharge from hospital, including prioritisation of fast track Continuing Health Care (CHC) funded service users
- support the smooth, safe and timely transition of care from hospital
- reduce the length of stay and prevents unnecessary delays to discharge
- reduce the number of people admitted into long term residential care directly from hospital
- reduce the risk of hospital acquired infection by keeping length of in-service user stay to a minimum
- reduce excess bed day costs

3.2 The main objectives of the service are to:

- identify all service users registered with a Somerset GP, who have been admitted to the RUH, on a daily basis and advise the individual service user's GP
- obtain the service user's expected date of discharge, clinical criteria for discharge and information on complexity
- undertake regular reviews, expediting actions, anticipating and identifying blocks to timely discharge and identifying/implementing possible solutions
- recognise the interdependence and required liaison between various agencies/stakeholders and improve relationships
- promote service user independence
- increase service user and carer confidence in the discharge process

SERVICE DESCRIPTION/CARE PATHWAY

Description

3.3 The service is hosted by the Provider on behalf of all Somerset GP practices.

3.4 The Provider will staff the service with appropriately qualified nurses who will provide an on-site in-reach service to the RUH.

3.5 The service will initially be provided primarily between 8.00 and 17.00, making best use of available resources to provide maximum on-site cover Monday to Friday.

3.6 The Provider will use available information to identify admitted Somerset service users and receive referrals from the RUH to support safe, timely discharge of service users to:

- home
- a nursing or care home
- a community hospital where specific on-site support is requested to expedite discharge
- any other destination such as neurological rehabilitation, hospice and for the homeless, by liaising with the appropriate District Council

3.7 A daily list of all new Somerset in-patients shall be communicated to Somerset GP practices, together with a daily discharge list which supports early primary care follow up.

Pathway

3.8 All service users registered with a Somerset GP, who have been admitted to the RUH shall be identified on a daily basis and advised to the individual service user's GP.

3.9 Service user expected date of discharge, clinical criteria for discharge and information on complexity shall be obtained.

3.10 Service users shall be assigned to one of the following complexity categories:

- Simple (for e.g., signposting only provided)
- Complex (for example only requiring a package of care)
- Highly Complex (for example, where there are multiple issues requiring multi-agency input which might include safeguarding issues, service user not having mental capacity, fast track CHC service users)

3.11 Those service users with potential 'complex/highly complex' discharge needs shall be identified prior to becoming medically fit.

3.12 A list of service users deemed medically fit for discharge will be reviewed on a daily basis. This may include service users identified by the Service, in addition to those identified by the RUH.

3.13 Service user progress will be tracked, using available information and through attendance at relevant meetings, to identify in a timely manner those patients deemed medically fit for discharge, before they appear on the 'medically fit for discharge list (the 'green list') including as

appropriate:

- involvement in review of reported delayed transfers of care (DTOC)
- regular progress chasing meetings
- involvement in service user MDT meetings, including those where Continuing Healthcare is required
- involvement in emergency readmissions and review of medical records where appropriate, to facilitate successful discharge at the earliest opportunity

3.14 The Provider will liaise directly with the service user and/or their carer to ensure the proposed discharge pathway is appropriate.

3.15 Support will be provided to any existing in-reach services on an ad-hoc basis where necessary to expedite discharge, ensuring the identified pathway is the most appropriate for the service user.

3.16 The Provider will respond to complex issues, attending multi-disciplinary meetings as required with the service user/carer and all relevant stakeholders, to facilitate solutions which promote safe discharge; this may include, but is not limited to service users with a delayed transfer of care and service users accessing Continuing Health Care

3.17 A daily discharge list will be shared with individual GP practices to support early primary care follow up.

3.18 The Provider will be represented in RUH Trust wide escalation discussions with the Commissioner. This could be achieved by representation through other in-reach services which regularly participate in such discussions.

Record Keeping

3.19 The Provider shall maintain and properly store, appropriate records of:

- interventions with service users
- detailed notes where service users have received a service beyond one off advice
- any adverse incidents or near misses
- any other activity which will support monitoring of the service (refer to Paragraphs 3.30 – 3.32)

Consent

3.20 The service user and/or carer shall be encouraged to participate in the discharge process and shall be fully informed of the options available.

Patient Involvement

3.21 People accessing the Service should be involved in decisions about their treatment/management and where appropriate, given high quality information to enable them to make fully informed decisions regarding their ongoing care.

3.22 The Provider should encourage, consider and report any patient feedback (positive and negative) on the Service and use it to improve the care provided to patients, particularly where there are plans to alter the way the service is to be delivered or accessed (Refer to paragraph 3.32).

Accountability

3.23 The Service shall be supported by a designated Provider Lead GP.

Education and Training

3.24 The Provider shall ensure that all staff involved in providing any aspect of care under this service:

- have the necessary training and skills to do so
- attend regular clinical supervision meetings with the designated Lead GP, at least every 2 months.
- have their roles and competencies reviewed as part of the annual nursing appraisal and revalidation process, to identify any further training needs
- access the expertise of other professionals where necessary

REPORTING AND MONITORING

Reporting of Significant / Adverse Events

3.25 The Department of Health emphasises the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.

3.26 The Provider should be aware of (and use as appropriate) the various reporting systems such as:

- the National Reporting and Learning System (NRLS). Reports to NRLS can be submitted electronically via the General Practice Patient Safely Incident report Form, or the national GP e-form. If using the GP e-form please check the box to share your report with Somerset CCG
- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices; and
- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.27 In addition to their statutory obligations, the Provider will notify the Commissioner within 72 hours of being aware of the hospital admission or death of a service user being treated by the Provider under this enhanced service where the Provider believes that the treatment was a significant contributor to the cause of admission or death.

3.28 The Provider will report all significant events which the service has been involved in to the CCG within 2 working days of being brought to the attention of the Provider, via the Medications Incident Report icon or via the CCG Feedback icon on the GP desktop.

3.29 In addition to any regulatory requirements the CCG wishes the Provider to use a Significant

Event Audit system (agreed with the Clinical Commissioning Group) to facilitate the dissemination of learning, minimising risk and improving service user care and safety and forward the completed SEA report to the CCG within one month of the event.

Monitoring

3.30 The Provider shall undertake continuous monitoring of the Service and have processes in place to respond to any identified issues in a timely manner.

3.31 In addition, the Provider shall advise the following information for each service user supported within the service, within 10 working days of the end of each month for the first 3 months and then within 10 working days of the end of each quarter:

- the number of service users supported each day split by the service user 'categories' described in paragraph 3.10.
- service user unique pseudonymised identifier
- the date the service user was identified to the Service (whether or not medically fit')
- the date the service user became medically fit for discharge
- all service users not discharged within 24 hours of becoming medically fit and the reason for the delay, for example:
    - social care placement not available
    - private care placement not available
    - family unsupportive
    - medical reason
    - other
- if a Delayed Transfer of Care (DTOC) occurred if the service user is at the 'end of life' and if they died in their place of choice

3.32 An annual review of the service shall be undertaken and forwarded to the Commissioner at least annually. The report shall include, but not be limited to, the following information:

- confirmation that staff providing the service have had their roles, educational needs and competencies reviewed
- case studies illustrating the benefit of the service and any learning to improve the service
- significant events the service has been involved in and the sharing of learning
- feedback on the service from patients/carers identified as having 'complex discharge needs' in the form of a brief continuous patient survey and also from the RUH to establish whether the Trust perceived it has benefitted from the service (The Patient Survey could be 2 questions: a friends and family type question plus 'Do you consider the intervention of the service enable the service user to get home quicker than had the service not been received?'. For the RUH – this would involve a once a year formal question and respond from, potentially, the various Directorate Matrons

Payment

3.33 The Service is subject to a local price, which is set out in Schedule 3 Part A of the NHS

Standard Contract.

3.34 Payments will be made on a monthly basis.

Population covered

3.35 All RUH inpatient service users registered with a GP practice in Somerset.

Any acceptance and exclusion criteria and thresholds

3.36 Service users from outside the service Commissioner's boundary and not registered with a GP practice in Somerset

Interdependence with other services/providers

3.37 The service will work collaboratively and or jointly with a range of other staff, teams and organisations where this is likely to optimise positive outcomes for the service user, their family members or carers and to maximise the use of the services resources. Key organisations include:

- Royal United Hospitals Bath NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Somerset GP practices Country Practice
- Somerset County Council
- Care Homes
- Clinical Hubs and Health Connectors

4. Applicable Service Standards

Applicable national standards (e.g. NICE)

4.1 None identified

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.2 None identified

Applicable local standards

4.3 Not applicable

5. Applicable quality requirements and CQUIN goals

Applicable Quality Requirements (See Schedule 4A-D)

5.1 >95% of 'complex' / 'highly complex' Somerset inpatient discharges are supported by the

	Service as a % of total Somerset discharges
5.2	%[1] of 'complex' / 'highly complex' Somerset inpatients identified by the Service as medically fit, but not identified by the RUH on its 'medically fit for discharge 'green list', as a % of all Somerset service user discharges *Note: The Standard for this Quality Requirement will be determined at the stated review date on page 1 of this specification*
5.3	>95% of fast track Continuing Health Care (CHC) funded service users discharged to their preferred place of choice to die as a % of all fast track Continuing Health Care (CHC) funded service users discharged
5.4	<5% of Somerset inpatients identified by the Service as medically fit for discharge accumulate additional bed day tariff costs **Applicable CQUIN goals (See Schedule 4E)**
5.5	As applicable

6. Location of Provider Premises

The Provider's Premises are located at:

6.1 As per the Particulars of the NHS Standard Contract

[1] Standard for Quality Requirement 5.2 to be implemented three months after service implementation