

## Service Specification

<b>Service</b>	<b>Seamless Home from Hospital service</b>
<b>Commissioner Lead</b>	Helen Wraith (CCCG) and Rebecca Spavin (GHCCG) Dr Helen Davies – CCCG Governing Body Lead
<b>Provider Lead</b>	
<b>Period</b>	
<b>Version</b>	Final May 2018
<b>Date of Review</b>	

### 1. Population Needs

#### 1.1 Local context

This specification provides a description of the Seamless Home from Hospital (SHFH) service to patients meeting the referral criteria in Section 3.2

Patients referred to SHFH will be resident in Calderdale or Greater Huddersfield CCG areas. They will have presented at or been admitted to Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH). In some cases the patient may have subsequently been transferred to Intermediate Care.

SHFH provides a service to patients to avoid admission and those being discharged:

- The service to patients avoiding admission is offered as part of the Integrated Admission Avoidance service, in conjunction with the Hospital Avoidance Teams (HAT). These patients will have presented at A&E at HRI or CRH. Clinical staff will have determined no clinical reason to admit to an inpatient ward but the patient is frail or vulnerable and needs additional support to ensure their safety and wellbeing to return home.
- Patients being discharged will have been inpatients at HRI, CRH or an associated Intermediate Care facility. Patients will be medically fit for discharge however may be frail or vulnerable and need additional support to ensure their safety and wellbeing going home.

### 2. Outcomes

#### 2.1 NHS Outcomes Framework Domains & Indicators

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

#### 2.2 Local defined outcomes

The wider local outcomes are aligned to those in the Care Closer To Home specification.

### 3. Scope

#### 3.1 Aims of service

The service will contribute to the delivery of Calderdale and Greater Huddersfield objectives of promoting health and wellbeing and commissioning and providing the best possible care for patients. The aims of the service are to contribute to a reduction in avoidable hospital admissions and delayed transfers of care. Avoidable admissions include admissions from A&E for non-clinical reasons and readmissions after discharge.

### **3.2 Service Description and Pathways**

- Referrals to SHFH will be made by a discharge coordinator, HAT team member, clinician or support staff acting for a clinician, on behalf of a patient currently located at CRH, HRI or Intermediate Care.
- All referrals will be made by phoning the SHFH coordinator 0300 020 0213. The coordinator will complete a new referral form during the call. The referrer and coordinator will arrange the time and place the patient will be collected from and the service they will receive.
- There are three types of service available: transport only, transport and settling in and settling in only
- Almost all patients will travel with SHFH in an accessible minibus (mobility codes T1-2 & W1-2). Two SHFH staff, a driver and a passenger assistant, will meet the patient at an agreed location within the hospital. Where appropriate patients will transfer to a wheelchair for the journey through the hospital, the second staff member carrying their bags. Patients are lifted into the minibus on the tail-lift and usually transfer to a seat for greater comfort during the journey. Passenger assistants have essential items to keep patients warm and dry.
- Exceptionally, where a patient needs a stretcher, 4-person lift or carry chair, either due to their condition or due to the number of steps at home, they will travel with Yorkshire Ambulance Service or private ambulance as available.
- In most cases a SHFH support worker will meet the patient as they arrive home. The support worker's role is to ensure the patient is safe and comfortable at home. This will include a safe and warm check, preparing food and drink and/or ensuring the patient has essentials to prepare their own food and drink. Support workers do not offer personal care but will undertake a wide range of tasks including turning on heating, making beds, clearing out the fridge, shopping etc.
- SHFH staff will assess the patient's home and ongoing support needs. This may result in referrals for equipment and home adaptations, or to a wide range of public sector and voluntary sector support services. Referrals will be made by the SHFH coordinator or support worker either directly, for example to the CMBC Handyperson service or voluntary sector services, or through Gateway to Care.
- The SHFH coordinator will make a follow up phone call to the patient 1-3 days after their return home in order to gauge if any further support is required. This call may result in further referrals or a follow up visit by a SHFH support worker. The SHFH coordinator will not sign off a patient until they are confident that the patient has sufficient support to live safely at home. The aim is to reduce readmissions due to preventable causes, such as falls.
- Referrers may sometimes refer to SHFH patients who are returning to a setting where care is provided, such as a residential home. These patients will typically need additional support on their journey and may be at risk of delayed discharge if appropriate transport is not available within the required time. SHFH will alert social services if there is any apparent inequity of provision due to a patient being out of their residential local authority area. (e.g. Calderdale resident in HRI)
- If the SHFH coordinator judges that the initial referral should have been to a HAT team, the HAT team will be contacted and asked to review the patient's circumstances. This will save time and ensure a timely safe discharge.

#### **Days/Hours of Operation**

On weekdays the SHFH booking line is available 9am-7pm, offering transport from hospital 10am-8pm and support at home 10:30am-9pm. On weekends and bank holidays the SHFH booking line is available 11am-6pm, offering transport from hospital 11am-6pm and support at home 11am-6pm.

#### **Referral Criteria and sources**

- The service shall be made available to frail and vulnerable adults (16 years plus) resident/registered with a GP in Calderdale and Greater Huddersfield CCG areas.
- Referrals will be accepted from any discharge coordinator, clinician or support staff acting on behalf of a clinician, HAT team member or hospital social worker based at CRH, HRI or Intermediate Care.

- Patients will be collected from any location at CRH, HRI or Intermediate Care.

### **Referral Routes**

- Referrals to SHFH on 0300 020 0213.
- Referrals to SHFH can be taken 9am-7pm on weekdays and 11am-6pm on weekends and bank holidays. On weekdays transport from hospital is available 10am-8pm and support at home 10:30am-9pm. On weekends and bank holidays transport and support are both available 11am-6pm.
- Referrals may be made as part of discharge planning or on the day of discharge.
- For patients avoiding admission, referrers will only need to make a single referral therefore a clinician referring a patient to a HAT team will not need to make a further referral to SHFH.

### **Response time and prioritisation**

- SHFH will agree with the referrer a suitable time to collect the patient, allowing for any wait for medication etc. The patient will be collected within 30 minutes of the agreed time. Where SHFH staff are delayed by more than 10 minutes the SHFH coordinator will contact the referrer to explain and provide the new expected arrival time.
- Prioritisation will generally be based on the “first referred, first served” principle. However, where a patient needs to be home by a particular time, for example for a care visit, the SHFH coordinator will accommodate wherever possible.

### **Population covered**

The service shall be made available to people who are frail and vulnerable adults (16 years plus) resident in Calderdale and Greater Huddersfield CCG areas.

### **3.5 Any acceptance and exclusion criteria and thresholds**

#### **Exclusion Criteria**

The following patients will not be eligible for referral to SHFH and will be signposted by a competent practitioner to alternative services as appropriate:

- Patients who are not medically fit to leave hospital.
- Patients under 16 years of age
- Patients who are not frail and not deemed vulnerable

### **3.6 Interdependence with other services/providers**

#### **Interdependences**

Effective partnerships with the following services are needed for safe discharges:

- Greater Huddersfield and Calderdale HAT Teams
- Discharge Coordinators
- Effective partnerships with the following services are needed for onward referrals to help prevent readmissions:
  - Gateway to Care in Calderdale and Kirklees
  - Handyperson Services
  - Voluntary Sector Services including befriending, cleaning, shopping, voluntary car service, day centres, lunch clubs, etc., provided by various organisations

SHFH will also work with:

- Calderdale and Huddersfield Foundation Trust Services, such as:
  - Support and Independence Team
  - Community Nursing Teams
  - Community Matrons
  - Rapid Response

Greater Huddersfield and Calderdale Adult Social Care Services, such as:

- Reablement Teams
- Social Workers

- Greater Huddersfield and Calderdale CCGs
- Primary Care
- Locala
- Out of Hours Services
- Yorkshire Ambulance Service
- Hospital Departments

#### **4. Applicable Service Standards**

##### **4.1 National/local targets and standards**

The Provider shall deliver the service in line with all relevant national/local targets and standards, which include those as set out below.

- CQC Essential Standards of Quality and Safety
- Health and Social Care Act (2008)
- NHS High Quality Care for All (2008)
- National Service Frameworks
- National Institute for Health and Clinical Excellence (NICE) guidance and guidelines including Safe Staffing Guidelines 1
- Mental Capacity Act 2005
- Deprivation Of Liberties Safeguards
- Local Transport Act 2008
- Quality for Health

The service shall be adapted or developed in response to new guidance, evidence-based practice and policy, including those as set out above.

Where a change in policy or guidance is likely to have a material impact on costs or practice, the Provider shall notify the Commissioner prior to any change in order to agree action as appropriate.

##### **4.2 Improving service user and carers experience**

- The provider will actively gather patient/carer experience data
- The provider will review patient/carer experience data on a quarterly basis, make recommendations where appropriate and act on them
- The provider will make available to the CCG patient/care experience intelligence when requested
- The provider will be expected to comply with their organisation's adult and children Safeguarding Policy

##### **4.3 Unplanned admissions**

SHFH, working with the HAT teams as part of Integrated Admission Avoidance, will contribute towards the overall decrease in unplanned admissions and readmissions in line with the strategic direction set out by commissioners.

##### **4.3 Reducing inequalities**

The Provider shall have systems/procedures/policies in place to demonstrate action taken to ensure the service is accessible to vulnerable groups. Health inequalities as a whole can only be reduced locally if a partnership approach is taken to tackle all the determinants. This service shall contribute towards the Calderdale and Greater Huddersfield CCG's response to the aspects of inequalities set out below:

- The wider determinants of health, such as employment, education, housing and

environment

- Lifestyles or health behaviours such as, smoking alcohol abuse, lack of physical activity or poor diet/nutrition.

The application of principles around Every Contact Counts would be seen as evidence of good practice, as would ensuring that these factors influence the provider's approach to ensuring safe and effective discharge.

#### **4.5 Reducing Barriers**

The Provider shall have systems, procedures and policies in place to identify and address specific issues that are potential barriers to access, and will review these on a regular basis to ensure they are effective.

#### **4.6 Improving productivity**

The Provider will be expected to take all necessary steps to optimise patient flow through the service, and to provide details to the Commissioner of action taken and its outcomes.

#### **4.7 Medicines management**

SHFH staff will not administer medicines but will prompt and provide basic assistance at the request of the patient, such as fetching a glass of water.

#### **4.9 Provider Compliance with Safeguarding Standards**

The CCG have in place comprehensive safeguarding standards for services who deliver care and treatment to children and adults, of which child and adult protection/safeguarding is a key component in all contracts with provider organisations. The provider is expected to adhere to standards that are relevant to their service, particularly:

- Have in place an identified safeguarding Lead for safeguarding children and adults and a Prevent Lead for staff to seek support and advice from
- All staff must undertake safeguarding adults and children training appropriate to their role and grade, This includes all staff must have at least an awareness of the Government Prevent Strategy among that is in line with the NHS England Prevent Training and Competencies Framework
- Be able to demonstrate staff compliance with agreed multi-agency Safeguarding procedures for adults and children (Safeguarding Adults the West Yorkshire, North Yorkshire and York Multi-agency Policy and Procedures & West Yorkshire Consortium Procedures Safeguarding Children), the Mental Capacity Act & Child Sexual exploitation processes
- Adherence to safe recruitment policies and practices which meet Employment check standards including ensuring that appropriate CRB/DBS checks are completed and repeated with national requirements and guidance.
- Ensure that all contracts of employment (Including volunteers, agency staff and contractors) include an explicit responsibility for safeguarding children and adults
- Ensure that there is a system for monitoring complaints, incidents and service user feedback, in order to identify and share any concerns of abuse (including potential neglect), using multiagency safeguarding procedures.

#### 4.10 Quality Performance Indicators

Quality Performance Indicator	Indicator	Threshold	Measurement
Improving Service User & Carer Experience	Patient experience: Service actively gathers service user/carer experience	75% Analysis of service user/care experience provided. Evidence of action taken on feedback from service users 2 case studies	Reviewed at Quarterly Review Meetings
Reducing Inequalities	Postcodes of people accessing service Age and ethnicity monitoring (and protected characteristics) collected as part of the referral	Evidence of action taken to ensure service is accessible	Reviewed at Quarterly Review Meetings
Improving Productivity	Workforce indicators – staff sickness absence, turnover, education and training		Reviewed at Quarterly Review Meetings

#### 5. Applicable quality requirements and CQUIN goals

- 5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D]) – not applicable in this specification.
- 5.2 Applicable CQUIN goals (See Schedule 4 Part [E]) - as CHFT have a Trust wide CQUIN scheme this is not applicable in this specification.

#### 6. Location of Provider Premises

SHFH coordination and transport based at CTC offices in Luddendenfoot. Support workers based at Age UK C&K across Calderdale and Kirklees.

#### 7. Activity

##### 7.1 Performance Indicators

Performance Indicator	Threshold	Report due
1. Number of referrals: a. Total b. Type (transport only, transport & settling, settling only) c. Postcode d. Accepted/Declined e. Declined by reason f. Response time by agreed time categories	100 referrals per month	Collated monthly reported Quarterly

2. Demographics: a. Age b. Gender	N/A	Collated monthly reported Quarterly
3. Onward referrals/activity as appropriate for the needs of the service user to brief interventions and activities a. Number of follow up calls undertaken b. Onward referrals by service/intervention	Year 1 Baseline	Collated monthly reported Quarterly
<p><b>7.2 Activity</b> The Provider will provide a quarterly performance report against the indicators set out above by the tenth working day after the end of each quarter, or as agreed between the Commissioner and Provider.</p> <p><b>7.3 Capacity Review</b> Capacity and demand will be reviewed regularly at Quarterly Review Meetings. Using the demand/capacity trajectory showing the number of cases that can be expected to be dealt with from the outset (use the monthly report to support this)</p>		
<p><b>8. Prices &amp; Costs</b></p>		
<p>£316,094 per annum</p>		