

Annex 1

Operational Process for Acute Discharge Teams within the Adult Social Care Structure 2019

Draft 5 – 4th April 2019

These Procedures should be read in conjunction with the Guidance on Core Responsibilities for the Adult Social Care Structure.

1.0 Simple Discharge Pathway.

The Simple Discharge Pathway relates to the majority of patients where discharge planning is Case Manager / Nurse-Led and where the input of multi-disciplinary hospital discharge services is not required.

In some areas Case Managers within Acute Trust Discharge Teams are able to arrange the simple restart of suspended services, where no additional assessment or commissioning activity is needed.

2.0 Complex Discharge Pathway.

The Complex Discharge Pathway applies to the minority of patients where an assessment has been undertaken by ward staff at the point of admission, or as soon as possible thereafter, and it has been identified that a Social Care Assessment is likely to be needed because:

- The patient is not receiving any Personal Social Care Services and there is an anticipated need for support on discharge.
- The patient is already receiving Personal Social Care Services and requires some modification to an existing package of care.

3.0 The Acute Discharge Team.

The Acute Discharge Team function within Adult Social Care has a lead responsibility for Hospital Discharge and have responsibility for the discharge teams in each Acute Trust across Lancashire.

Staff in the Acute Discharge Service will work closely with Acute Trust Case Managers to improve the patient journey through early and proportionate assessment, speeding up discharge and reducing unnecessary delay.

4.0 Referral or Assessment Notification Process (Formerly Section 2 Notifications).

4.1 Referral should be made using the current documentation for Referral/Contact Assessment and Assessment Notification as applied in each hospital. Consent from the patient must always be secured prior to the referral being made.

4.2 In some cases where patients appear to have significantly high needs, the Referral and Assessment Notification will not be accepted until screening for eligibility for Continuing Health Care (CHC) has been completed, consent to the referral has been obtained from the patient and there is evidence that Estimated Date of Discharge has been determined as part of a clinically led treatment plan (*Please refer to the [National Framework for CHC&FNC, 2018](#)*)

4.3 Referral information should be entered onto Liquid Logic (LAS) (As a new referral) by one of the following, in accordance with current local arrangements:

- Acute Trust Discharge Team Staff or Admin.
- Staff in the Acute Discharge Service
- Customer Service Officers at Customer Access Centre.

4.4 Completed Referral information should be sent to the relevant Discharge Team Mailbox, for the appropriate area as follows:

- HOSPITAL INTAKE - FYLDE & WYRE
- HOSPITAL INTAKE - LANCASTER & MORECAMBE
- HOSPITAL INTAKE - CHORLEY SOUTH RIBBLE
- HOSPITAL INTAKE - WEST LANCS
- HOSPITAL INTAKE - PRESTON
- HOSPITAL INTAKE - EAST LANCS HOSPITALS

Under the new pathway of Home First and in some cases for the reablement, completed referral information should be sent to the Intermediate Care Teams through the agreed local process for each Hospital;

- ICAT HOME FIRST (East Lancashire)
- ICAT MORECAMBE BAY
- CATCH (Central Lancashire)
- CERT WEST LANCS

Using the Liquid Logic Message: ***Discharge Team Referral (DTR)***.

4.5 Acute Discharge Service workers will screen **all** new referrals in the Hospital Discharge Team LAS Tray and Mailboxes.

4.6 Acute Discharge Service workers will check the referral information to ensure that the referral is appropriate, screening for eligibility for Continuing Health Care has been completed, consent to the referral has been obtained from the patient and that an accurate Estimated Date of Discharge has been recorded.

4.7 Where necessary the Acute Discharge Service worker will work with the Acute Trust Admin Staff, Case Managers and ward staff to obtain any additional information required, including evidence that the Estimated Date of Discharge has been determined as part of a clinically led treatment plan.

The aim is to enable the Referral and Assessment Notification to be accepted as early as possible in the patient journey to allow sufficient time for appropriate allocation, assessment and discharge planning.

4.8 The Acute Discharge Service worker will update the LAS record to indicate that the Referral and Assessment Notification has/has not been accepted.

4.9 Where arrangements are already in place for Case Managers to restart suspended services, where no additional assessment or commissioning activity is needed, this should continue. The Acute Discharge Service worker would usually only arrange the restart of services where re-commissioning was required.

5.0 Initial Assessment and Allocation

5.1 The Acute Discharge worker will undertake an initial assessment for new and existing service users to enable one of the following outcomes:

- Conclusion of the case with the provision of advice and information.
- The commissioning of a temporary time limited service to support recovery, and subsequent closure of the case.
- Commissioning of Reablement or other Intermediate Care Services.
- Provision of Community Equipment Prescriptions.
- Initiation of contact with relatives and carers at an early stage in order to gather additional information and to start the discharge planning process, where appropriate.
- Appropriate and timely allocation for more complex level of assessment (overview) by the hospital service or by the community worker where a patient is known or open to a community social care worker.

5.2 The Acute Discharge Service worker will either be allocated the case or will allocate the case to themselves as primary worker (on LAS).

5.3 The Acute Discharge Service worker will arrange transitional care services to facilitate timely discharge and to enable further assessment to be undertaken in a non-acute or community setting wherever possible.

5.4 Reference should be made to the local procedures for accessing the new discharge pathways (***Home First & Discharge to Assess***) and Intermediate Care and other Transitional Care Services that are available in each area.

5.5 *Acute Discharge Service workers will apply the LAS procedures for the commissioning of services from a LAS Screening Tool / Overview Assessment (OV) (version 7) or review request using the LAS support plan if an OV assessment has recently been completed and is still within budget of the services being requested. These procedures enable the commissioning of*

temporary support for up to 6 weeks, Community Equipment, The Reablement Service, Domiciliary and Residential Intermediate Care Services and Short Term Care, prior to the completion of the Overview Assessment and Personal Support Plan (where the screening tool is being utilised, for people being discharged from hospital).

5.6 The Acute Discharge Service worker will complete a detailed LAS screening tool / Overview assessment, support plan and case notes to clearly record the assessment information, services arranged or other action taken during the Initial Assessment.

5.7 Where the initial assessment indicates that the referral was suitable for completion at this stage with a predicted outcome of either:

- Conclusion of the case with the provision of advice and information only
- Or
- Commissioning of a temporary time limited service and subsequent closure of the case.

The Acute Discharge Service worker will send the record to the delegated Manager on LAS for closure of the episode with a summary case note explaining the reason for closure.

5.8 In the event of a request being made for a temporary service to be extended for any reason, the request will be managed by the Acute Discharge Service worker.

5.9 Both Acute Discharge Service workers and Case Managers can complete a Screening Tool on LAS to request for Intermediate Care Services to be provided. Where the Acute Discharge Service worker or a Case Manager have commissioned Intermediate Care Services from a **Screening Tool**, the case will be sent to the Intermediate Care Allocation Teams (ICAT, CATCH, CERT) for allocation within the Intermediate Care Service for the onward management of the case to the point of closure (*Intermediate Care Allocation Services in some areas of the County are currently either being developed or are relatively new*).

5.10 Where the Acute Discharge Service worker has referred to the Reablement Service the procedures within the [Reablement PPG](#) will apply.

5.11 Where Initial Assessment indicates that further assessment (CHC) is needed prior to discharge, the Acute Discharge Service Social Care Support Officer (SCSO) will record the work that has been undertaken to date and the

reason for the required allocation to a Social Worker on a Case Note Summary.

5.12 The onward allocation of the case will be recorded on the Acute Discharge Team passport to independence tracker / DToC Tracker. This will facilitate caseload management within Acute Discharge Teams and ensures that Hospital Discharge activity is monitored.

5.13 When all assessments have been completed and the patient has been discharged, the allocated workers should send a notification on LAS to the DToC SCSO. This enables the progress of all hospital referrals to be monitored and recorded accurately for Sit Rep reporting.
(See section 8)

6.0 Existing Service Users with an Active Worker

6.1 Where the Acute Discharge Service worker identifies that a referral relates to an existing Service User with an active Community Worker they will complete the process for accepting Referrals and Assessment Notifications as set out in **Section 4 above** and will notify the active Community Worker to complete the discharge planning.

6.2 The Acute Discharge Service worker will gather and record sufficient information to ensure that the Community Worker is provided with good quality referral information to support decision making and to prevent unnecessary assessments within hospitals.

6.3 The Acute Discharge Service workers will offer a liaison service for active workers but will not be responsible for all communication between active workers and ward staff.

6.4 Where there is an active worker in the community, they will be responsible for discharge planning and will work within the prescribed discharge regulations and timescales.

7.0 Discharge Notifications (Formerly Section 5 Notifications)

7.1 Discharge Notifications will be entered onto LAS by one of the following, in accordance with current local arrangements:

- Acute Trust Discharge Team Staff or Admin.
- Staff in Acute Discharge Service.
- Customer Service Officers at Customer Access Centre.

7.2 The LAS case notification or contact record message will automatically be sent to the Allocated/Active worker. The person who enters the Discharge Notification on LAS **must** send a LAS Message to the Hospital Intake Tray as well as to the Active Worker.

This will alert the Acute Discharge Service worker and the Duty Officer that a Discharge Notification has been issued and that progress monitoring will be needed.

8.0 Monitoring the progress of Pre- Discharge Assessments for Sit Rep

8.1 The Acute Discharge Service will be responsible for monitoring the progress of pre-discharge assessments in order to report to Acute Trust Discharge Managers as needed to produce and agree the DToC SitRep report.

8.2 The Hospital Intake LAS Duty Tray will be managed by the Acute Discharge Service workers who will access the LAS records of all people for whom a Discharge Notification has been issued, to ensure that discharge is being arranged within the required timescales.

8.3 Acute Discharge Service workers may advise active community workers where action is needed to progress discharge plans in order to avoid Delayed Transfers of Care that are attributable to Lancashire County Council on the Sit Rep.

8.4 Where the active community worker appears to be unavailable, the Acute Discharge Service worker will send a LAS message to the Locality Tray to ask for the Team Duty Officer to support the discharge in the meantime. This will act as an alert that work is needed in the event of the active worker being absent.

8.5 Where necessary the Acute Discharge Service workers will alert the appropriate managers of any potential delays.

8.6 The Acute *Passport to Independence* spreadsheet / Tracker will be used as a tool to monitor the progress of all referrals that are within the discharge planning process and to record the actual date of discharge.

(NB. Sections in italics may indicate that additional guidance is being developed for this process).

9.0 Safeguarding Guidance – Poor Discharge from Hospital

9.1 Poor Discharge from Hospital When should a [Safeguarding Adult Concern](#) be raised?

- Where there is insufficient discharge or transfer of care planning from any area resulting in an adverse effect on the adult at risk.
- Where the adult is discharged without necessary medication, equipment or clothing and this has an adverse effect on the adult at risk.
- Where the patient is discharged with cannula in situ and has an adverse effect on the adult at risk.
- Where the patient is discharged with no/or incomplete discharge letter and has an adverse effect on the adult at risk.

9.2 Poor Discharge from Hospital When don't I need to report a Safeguarding Adult concern?

In the following instances complaints or incident management procedures should be used. A Safeguarding Concern does not need to be made in the following instances;

- Where there is insufficient discharge or transfer of care planning from any area and there is no adverse effect on the adult at risk.
- Where the adult at risk is discharged without necessary equipment or clothing and there is no adverse effect.
- Where the adult at risk is discharged with cannula in situ and there is no adverse effect.
- Where the adult at risk is discharged with no / or incomplete discharge letter and there is no adverse effect.
- Where there is a failure to communicate the treatment plan (E.g. Now has catheter in situ, tissue damage present etc) and no adverse effect occurs