Document Type: **Policy**	**Unique Identifier:** CORP/POL/198
Document Title: **Transfer of Care Policy**	**Version Number:** 1 **Status:** Ratified
Scope: Trust wide and health and social care system partners (particularly colleagues working within the Transfer of Care Hub)	**Classification:** Organisational
Author / Title: Sharon Doyle - Discharge Lead (RLI) Tracy Ashton - Discharge Lead (FGH)	**Responsibility:** Transfer of Care Hub
Replaces: Version 9.3, Discharge Policy, Corp/Pol/079	**Head of Department:** Dee Houghton - Deputy Chief Operating Officer
Does this document refer to and account for the prescribing, supply, storage or administration of medication (especially via electronic media)? **No**	
Validated By: Dee Houghton, Deputy Chief Operating Officer Community Lynne Wyre, Deputy Chief Nurse Morecambe Bay Discharge Steering Group	**Date:** 08/11/2022 08/11/2022 09/11/2022
Ratified By: Trust Procedural Documents Group	**Date:** 09/11/2022
Review dates may alter if any significant changes are made	**Review Date:** 01/04/2023

- Does this document meet the requirements under the Equality Act 2010 in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation? **Yes**
- Does this document meet our additional commitment as a Trust to extend our public sector duty to carers, veterans, people from a low socioeconomic background, and people with diverse gender identities? **Yes**

Document for Public Display: Yes

CONTENTS

1. SUMMARY

As outlined in the national Hospital discharge and community support guidance (2022) - '*Under Discharge to Assess, Home First approach to hospital discharge, the vast majority of people are expected to go home (i.e. to their usual place of residence) following discharge. The Discharge to Assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs.'*

This means daily reviews of people should identify whether they meet the Criteria to Reside (CTR*)* and people who do not meet these criteria are to be discharged to alternative settings.

Health and social care partners across Morecambe Bay are committed to ensure people return home at the earliest opportunity. Conversations with people and/or their carers about transfers of care should follow the principles of personalised care.

The Morecambe Bay Transfer of Care Policy is the local policy to support delivery of the national Hospital Discharge and Community Support Guidance.

This policy should be considered in conjunction with the following documents -

- Transfer of Care – Pathways and Processes
- Pathway Definitions: Lancashire & South Cumbria (please see appendix)
- Lancashire & South Cumbria - Hospital Discharge Standard Operating Procedure (currently version 5 - January 2022) - which includes model information leaflets for patients and Checklist for Discharge of all Patients to Care Homes

This policy, together with appendices and Transfer of Care Pathways and Processes Procedure, supports the transfer of care from the UHMB hospitals to the community.

The policy ensures person centred care, all agencies involved in the provision of social care, nursing, therapy, or medical care work together to deliver an effective, co-ordinated transfer of care.

Transfers of care are the responsibility of health and social care system partners and start with the avoidance of unnecessary admissions prior to attendance at hospital.

Transfer of Care Hub colleagues, from Furness General Hospital (FGH) and the Royal Lancaster Infirmary (RLI), will support the delivery of this policy (team members from the RLI also support transfers of patient care from the Westmorland General Hospital).

The principles of this policy are based on collaborative working, cooperation, and a shared system wide focus on people within the Morecambe Bay health and social care system.

2. PURPOSE

The purpose of this Policy is to ensure that transfers of care from hospital are safe and are

managed in a way that:-

- Puts the person at the centre of the process, supporting individuals and family or friend carers to understand both individual rights and policy constraints on choice to maximise engagement and control for people.

- Is compliant with duties under -

  - Hospital discharge and community support guidance (2022)
  - The Care Act (2014)
  - The Mental Capacity Act (2005)
  - The Mental Capacity (Amendment) Act (2019)

- Should be considered in conjunction with -

  - Pathway Definitions: Lancashire & South Cumbria (please see appendix 1)

  - Lancashire & South Cumbria - Hospital Discharge Standard Operating Procedure (currently version 5 - January 2022) - which includes model information leaflets for patients and Checklist for Discharge of all Patients to Care Homes

The principles of this policy are based on collaborative working, cooperation, and a shared system wide focus on people within the Morecambe Bay health and social care system.

3. SCOPE

Transfers of care and discharge must be seen as an interdisciplinary and/or multidisciplinary responsibility. Therefore, this policy applies to all permanent, locum and agency staff employed within statutory health, social care and housing services across the Morecambe Bay Place area and is delivered in partnership with the voluntary and community sectors (including commissioned services), citizens, family and friend carers and independent sector care providers across Morecambe Bay.

To ensure transfer arrangements take place in a safe and timely manner, discharge planning must start on admission, with an expected date of discharge (EDD) being identified pre-admission or within 48 hours of admission to hospital. This must be communicated to people being admitted and if appropriate their carers/relatives. An expected discharge pathway should be identified as early as possible during an acute admission recognising that this may change.

Where support may be needed to enable a person to return home or to another place for care for treatment then planning must start on admission with the identification of a supported discharge pathway. National guidance suggests that 95% of all discharges for people over 65 should be to a person's own home or place of residence, 4% should be for an on-going period of rehabilitation in a bedded setting and only 1% should be to a new residential or nursing facility .

Any transfers into nursing or residential care for a person who was not already in receipt of this level of care prior to admission must be agreed by the Transfer of Care Hub multi-disciplinary team in consultation with individuals and their carers and families.

Daily Board rounds and reviews must take place and be appropriately prioritised and

should follow best practice guidance and maximise opportunities to enable the person to return home.

This Policy, and accompanying procedure, guides the reader through the processes of transfers of care and identifies the roles and responsibilities of those involved in the transferring of care.

3.1 Roles and Responsibilities

Role	Responsibilities
Chief Executive / Trust Board Responsibilities	**University Hospitals of Morecambe Bay NHS Foundation Trust:** The Chief Executive and Trust Board have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory, and good practice requirements. **Local authorities (Cumbria, Lancashire and North Yorkshire):** The Director of Adult Services has statutory responsibilities for provision of local authority duties under part one of The Care Act (2014). **Lancashire and South Cumbria Integrated Care Board:** The Chief Operating Officer and the governing body have responsibility for the NHS commissioning functions of this policy and the delivery of the elements of the policy that relate to continuing health care delivery.
Executive Director Responsibilities	The following executive directors are responsible for the delivery of this strategy. • Chief Operating Officer, University Hospitals of Morecambe Bay NHS Foundation Trust • Director of Adult Social Care Services, Cumbria County Council • Director of Adult Social Care Services, Lancashire County Council • Director of Adult Social Care Services, North Yorkshire County Council • Chief Operating Officer, Lancashire and South Cumbria Integrated Care Board Each of the nominated Executive Directors will ensure appropriate level of resources are in place within their own organisational remit to deliver this policy and work cohesively to ensure system approach to transfers of care.
Pharmacy	Ward Pharmacist must be informed of any TTO requirements as early as is feasible noting that additional time is required for dispensing of medication using monitored dosage system (MDS) compliance aids/blister packs. The Pharmacy team will ensure; • All prescribed TTO medication is dispensed at least 24hrs before discharge. • People transferring under End of Life (with an End of Life

	care plan) should have anticipatory medications written and dispensed accordingly. • That when an individual is to be discharged with medication prescribed via injection or an infusion pump an authorisation letter is written to the district nurse confirming details of the prescribed medication to accompany the person on discharge. • The Electronic Discharge Summary should be completed. If unable due to IT breakdown, then a handwritten version should be legible on all copies provided. In line with best practice set out in the NHS Discharge Medicine Service the pharmacy team should refer patients to community pharmacy on discharge with information about medication changes made in hospital. Community pharmacy will support patients to improve outcomes, prevent harm and reduce readmissions.
Transfer of Care Hub	The ToCH will ensure: • Attendance at daily board rounds to support discharge conversations • Daily reviews take place for all people on pathway 1, 2 & 3 who do not meet the criteria to reside • Oversight and monitoring of discharge plans to support fluidity of patient flow. • A resource for colleagues across health and social care to support the development of discharge plans • A single point of access for problem solving and resolving / escalating issues with discharge • Monitoring progress and advise on the discharge process including identifying and reporting the reasons for any delayed discharges and ensuring that the electronic patient system, is updated accurately and promptly • Production of medically optimised reports and other performance data, working with Trust and Adult Social Care performance teams to support SITREPs and data returns. • Escalation processes are in place to resolve individual cases • Organisation and arrangement of transport including out of area transfers for people who do not meet the criteria to reside • Complete long length reviews of all people with a length of stay of 21 days or more and chair weekly long length review MDT • A case management function for people with complex discharge planning requirements. • Discharge plans for all people on End-of-Life pathways
Medical Staff	The Consultant or other appropriate doctor with delegated authority has responsibility for: • Working within SAFER principles to manage and facilitate discharge

	• Determining an EDD that is communicated to the individual, relatives/carer on admission and recorded in the persons notes and on e-Outcomes • All patients to have an EDD based on medical and functional suitability for discharge • Daily Senior Decision Maker review of people at Board Rounds • Prioritising reviews of potential discharges immediately following reviews of the sickest patients. • Ensuring that e-Outcomes is updated • Confirming the EDD on the first senior clinical review and ensuring that date is communicated to the multi-disciplinary team (MDT), the person and their relatives/. • Keeping the individuals/relatives/carers fully informed of their progress and treatment to progress assessment needs. • Completing Discharge Summaries • Liaising with the MDT on a regular basis to enable co-ordination of the agreed discharge date. • Ensuring any change in the persons EDD is communicated to the MDT/person/relatives and recorded on e-Outcomes and in the medical notes without delay. • Documenting clearly on e-Outcomes and in the medical notes when a person is medically optimised and no longer meets the criteria to reside. • Ensuring all TTO medication is prescribed at least 24 hours before discharge wherever possible.
Ward Manager / Senior Nurse	The Ward Manager / Senior Nurse will ensure that the Policy is adhered in particular: • Ensuring every person has a copy of the Discharge Leaflet and letters - as appropriate • Ensuring that all individuals have an EDD recorded on e-Outcomes and in their notes and that this date has been communicated to the patient, relatives/carer, as appropriate. • All information relating to the discharge is recorded one-Outcomes. • Ensuring that systems are in place so that the discharge is co-ordinated and progresses according to plan. • Jointly working to ensure review of people at daily Board Rounds • Continuously monitoring the discharge progress of people, ensure positive action is taken to expedite discharges for those who are fit to leave an acute bed and have exceeded their EDD. • Any delays to a person's progress (diagnostics, tertiary opinion, referrals) are reviewed and escalated
Ward Nurse / Therapist	The Ward Nurse / Therapist will ensure: • Discharge planning commences within 24 hours of admission and that progress is appropriate to achieve the

	EDD. • Liaison with Complex Case Managers to ensure consensus of information is provided • The person and relatives / carers are fully involved in the discharge planning process, their needs and wishes are considered, and they have at least 24 hours notices of the discharge date, whenever possible. • All information relating to the individuals discharge is recorded on e-Outcomes. • Medication is ordered 24 hours before the discharge wherever possible. • Appropriate transport arrangements are made in line with the transport protocol and that all pertinent information regarding the persons condition is given to the ambulance service transporting patients. (E.g., Do Not Attempt Resuscitation [DNAR] status, infections, issues regarding transferring/manual handling). • The receiving hospital, care home or social care facility (or community nurse team, if the patient is returning home) is notified of any known infection and the current infection control practices in place e.g., antibiotic therapy, dressing regime, barrier nursing. • The person has the necessary medication, dressings, continence products and relevant information about post discharge care • All arrangements and referrals in relation to discharge planning are clearly documented, signed, and dated within the discharge planning documentation. • All healthcare professionals involved with the person are notified of any change in the persons ward placement and or condition/suitability for discharge with a request for a review as appropriate. • Any potential delays in discharge are referred immediately to the ToCH as soon as they become known outlining the reasons for the delay or potential delay. • All necessary information for discharge/transfer of care and management is gathered, recorded, and communicated appropriately.
Managers	Managers are responsible for ensuring: • Operational delivery of the relevant aspects of this policy within their organisational scheme of delegation • Escalation of any issues that arise in the delivery of this policy that require a strategic or system approach
Partner Organisation Responsibilities	Colleagues, from the following organisations, have responsibilities for supporting transfers of care from hospital - University Hospitals of Morecambe Bay NHS Foundation Trust, Cumbria County Council, Lancashire County Council North Yorkshire County Council Cumbria Care

	NHS Lancashire and South Cumbria Integrated Care Board Barrow Borough Council Lancaster City Council, South Lakeland District Council North West Ambulance Service Lancashire and South Cumbria NHS Foundation Trust Midlands and Lancashire Commissioning Support Unit St. John's Hospice St. Mary's Hospice Voluntary sector organisations (including commissioned voluntary sector services)

4. POLICY

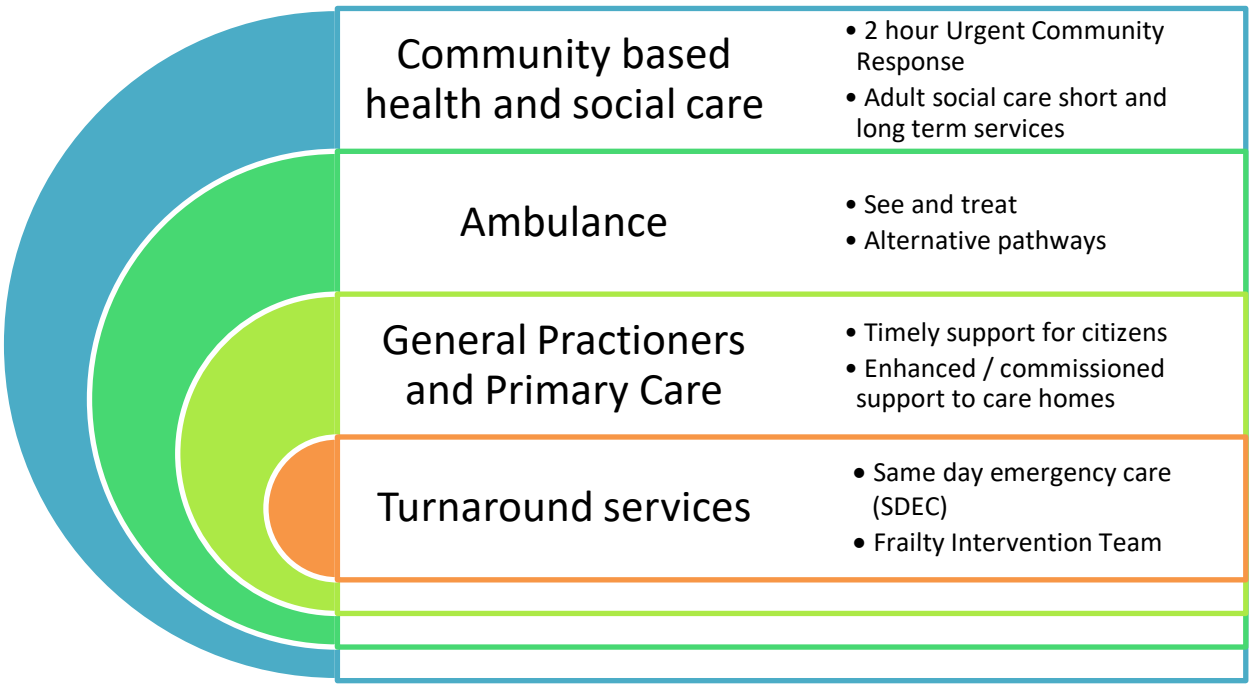
4.1 Principles

4.1.1 Right care in the right place - Admission Avoidance

Acute care beds should not be used as a place of safety if there are no medical needs. The system will take all steps to avoid unnecessary hospital admissions by ensuring that there are robust options available to support people in the community as an alternative to hospital-based care.

This policy will not repeat all the measures and pathways that are in place to avoid hospital admissions - however outlines the role of key partners in supporting this outcome.

The chart below shows the key routes to ensure a person who may otherwise be conveyed or admitted to hospital can be supported in a more appropriate way



4.1.2 2 Hour Urgent Community Response Hub

The 2 Hour Urgent Community Response Hub, led by UHMB colleagues, working with partner organisations across Morecambe Bay, will lead on ensuring people receive support within 2 hours when required, to prevent an avoidable admission to hospital.

4.1.3 Adult Social Care

Adult Social Care will work to deliver specific duties under The Care Act (2014), which support admission avoidance. This supported further by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Single route must be established to assess and consider peoples eligibility for care needs and support for carers, including a financial assessment where necessary.

Section 2 and 3 requires to take step to prevent reduce or delay needs for care and support for local people including the provision of housing.

4.1.4 North West Ambulance Service (NWAS) and North West Private Ambulance Liaison Services (NWPALS)

NWAS will utilise the three services it provides – 999 Patient Emergency Services (PES), NHS 111 and Patient Transport Services (PTS) to maximise support for admission avoidance and discharge of people who are medically optimised.

NWPALS will provide transport for those patients that require a Home First or Reablement assessment where transport cannot be provided by any other source such as relatives, Age UK Lancashire etc.

4.1.5 Primary Care & Out of Hours Providers

Primary care and out of hours providers will play a key role in admission avoidance and will also support their registered patients as needed following discharge.

Contact details for Out of Hours providers include -
NHS - 111
Cumbria Health on Call (CHOC) - 01228 514830
Fylde Coast Medical Services (FCMS) - 01253 951345

4.1.6 Frailty Intervention Team (FIT)

The Frailty Intervention Team (FIT) is a team of healthcare professionals who specialise in providing rapid assessment and treatment in the most appropriate place for our frail and older patients.

It is well recognised that early review by a multidisciplinary team is very beneficial for older patients when they present to hospital and also that hospital admission can carry significant risks for older patients. Therefore the principles of the Frailty Intervention Team are to:

- Provide older patients with an early multidisciplinary review, starting with Comprehensive Geriatric Assessment (CGA) at the earliest opportunity to avoid unnecessary hospital admission for older patients, helping them to return to their own environment if possible.
- Minimise the risk of muscle wasting that quickly occurs when older patients are resting in bed rather than remaining active.
- Assist supportive discharge and provide opportunities for follow up if needed either

within the community or in hospital if unable to discharge.

4.1.7 Transfer/Discharge from Emergency Department & SDEC

People who have been reviewed by the medical team in the Emergency Department, and are medically optimised for discharge and do not require admission, but for whom concerns have been raised regarding their ongoing care needs within their current residential setting, will be referred to the Transfer of Care Hub (ToCH) team for an initial review of their care needs, seven days per week. Following this assessment, onward referrals will be made to the appropriate services in the community to ensure a safe discharge, should further support be required.

The ToCH can also be contacted to support with any ongoing discharge support such as re-starting care packages, accessing Reablement and liaising with social work to assist complex discharge arrangements.

If a person is unable to return to their current place of residence, but still does not require admission into an acute bed, the ToCH will utilise all available step-up beds that can meet the needs of the person to avoid a social care admission.

4.2 Expected Date of Discharge (EDD)

A target discharge date to which all agencies can work (whilst recognising that the date may change according to the individual's needs/clinical status). An EDD should be set within 48 hours of admission to hospital, at the first Consultant review and no later than the first Consultant post take ward round the next morning. This should represent a professional judgement of when a person is anticipated to achieve his/her clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence).

An individual's progress towards EDD should be assessed every day at a board or ward round led by a senior clinical decision maker (normally the Consultant).

4.3 Supporting Patient Choices to Avoid Long Hospital Stays

A Lancashire and South Cumbria ICS task and finish group has considered home of choice, as detailed in the Care Act, and how it applies to discharge to assess guidance and mental capacity legislation.
ICS agreement around home of choice and how it should be considered and applied, alongside discharge to assess arrangements, have been embedded into the Lancashire & South Cumbria - Hospital Discharge Standard Operating Procedure.

Conversations must ensure that people are aware that initial choice may be limited as a Discharge to Assess bed is just a temporary bed, but that full choice is offered at the point of seeking a long term option. Similarly, choice with care agency provision should be considered.

Should concerns be raised, it is important to meet with the patient, their family, friends, carers and any external agencies to discuss the patient's concerns and try to agree a way forward.

A transfer of care date should be arranged; if the patient has capacity and still refuses to

leave, their licence to remain on the property should be removed.

It is important to follow the process, even if a patient does not engage.

Should a patient refuse to leave hospital -

- Implement the escalation process immediately
- Aim to resolve any disagreements without resorting to legal action
- Avoid threatening legal action
- Take a collaborative approach with other organisations
- Seek legal advice a point is reached where transfer of care under the escalation policy seems unlikely

For detailed process information, leaflets and model letters, please see 'Supporting Patient Choices to Avoid Long Hospital Stays'.

4.4 Board Rounds, Criteria and Discharge Pathway (Acute Hospitals)

Each Acute Ward area must run a daily board round.

Board rounds must include a discussion on whether a person meets the criteria to reside (CTR). People who do not meet the criteria to reside should be categorised as medically optimised for discharge. Once a board has been completed board / ward rounds date and time should be entered into e-Outcomes.

Board rounds should also be used to identify the appropriate pathway for discharge.

Pathways should be identified based on the principle of “no place like home” –considering that for the over 65 population 95% of people should be returning home and only 1% should be identified as requiring new nursing or residential placements.

Pathway identification should start as early as possible.

4.5 Transfer of Care Meetings

Daily multi-disciplinary meetings will take place for people in each of the acute sites.

Monthly agreed system review meetings will be held to ensure transparency and partner working is continually developed.

These will be arranged by specialism and locality as required.

Additional complex case reviews will take place as necessary.

4.6 Communication with Individuals and Carer’s / shared decision making

Good communication with individuals, relatives, family and friend carers and care providers should be prioritised by ward staff and the Transfer of Care Hub team.

A person who does not have family or friends, and who may find it difficult to understand, communicate or speak up, should be informed of their right to an advocate as set out in the Care Act (2014).

Information leaflets detailing arrangements for transfers of care appropriate to the hospital setting (acute or community) must be provided to a person on admission to hospital.

This must include relevant information on timing of financial assessments and charging arrangements for short term services.

Conversations with people and/or their advocates about transfers of care should follow the principles of personalised care. Assumptions should not be made about a person's preferences or wishes, and consideration should be given to balancing the question of *what is important **to** the person*? *And what is important **for** the person?* Taking this strengths-based approach will allow positive risk taking and promote shared decision making

Conversations with existing care providers should take place at an early stage to enable a timely transfer of care to take place and reduce the risk of care provision being withdrawn.

From 1 July 2022, Section 91 of the Health and Care Act was enacted, introducing a new duty for NHS trusts and foundation trusts to involve patients and carers (including young carers) in discharge planning[1].

Shared decision making is a joint process in which a healthcare professional works together with a person to reach a decision about care.

It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values.

It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing.

National Institute for Health and Care Excellence (NICE) guidance can be consulted for the latest information and best practice.

4.7 Families and/or Carers

The needs of unpaid family and friend carers must be considered alongside the needs of the person residing in hospital and they should be offered a proportionate carer's assessment under the Care Act (2014).

The formal carer's assessment can take place outside the hospital setting if this appropriate, but it is important to understand the carer's capacity and willingness to undertake care if this is an expectation to support a transfer of care.

A carers leaflet for people looking after friends or family when they leave hospital is available to support conversations with carers. Leaflets are available in each ward.

To support timely discharges family and friend carers who have been identified and have

agreed to provide short term support/care until an official commissioned service can be sourced, should be considered for referral to the Hospital Discharge Grant Scheme and/or One-off personal health budget within the hospital discharge pathway. Transfer of Care Hub colleagues will support to facilitate referrals.

4.8 Self-Discharge

People with capacity can choose to self-discharge and leave the hospital - even against medical advice.

If it is felt that a person lacks capacity and/or is under DOLS - colleagues will need to refer to the Deprivation of Liberty Safeguards Policy.

There are occasions when patients will be determined to leave hospital.

Every effort must be made by nursing and medical staff to persuade the patient to remain in hospital, or persuade the parent of the child that the child should stay in hospital and continue their treatment. When this fails certain action MUST be taken to protect the patient as much as possible.

The patient will be required to sign the Self Discharge form. This will clearly state that the patients are discharging themselves against medical advice. Should the patient refuse to sign the form this MUST be documented in the medical/nursing records and counter-signed by another member of staff.

The following action MUST be taken by the ward team in all instances where patients are discharging themselves from hospital:

- Contact the patient's next of kin (if appropriate)
- Inform the relevant Matron in the Care Group and named Consultant. In the absence of both, inform the Clinical Site Manager (CSM)
- Inform the District Nurse Liaison, if relevant
- Inform a member of Social Services, or Children's Social Care and. a member of the Children's Safeguarding Team, if relevant
- Inform the patient's G.P. as a matter of urgency
- Arrange appropriate transport, when necessary
- Inform the police, if applicable (e.g. when violence has occurred).

It is the responsibility of medical and / or nursing staff to document all information relating to the self-discharge in the patient's medical record.

Patients who leave the ward and fail to return should be considered as absconding and therefore the Trust Policy for Absconding Patients should be followed.

Patients who have been on approved leave from the hospital and fail to return at the expected time should be contacted by telephone in the first instance.

4.9 Complex Discharges

Being a "patient" can be disempowering and it is important that when considering transfers of care individuals are enabled to exercise as much choice and control over the process as

they are reasonably able to do without causing a delay to their transfer of care.

Discharge options must be discussed with individuals and family consulted as appropriate, considering all aspects including social circumstances, manual handling needs, mental capacity and best interest decisions.

Where there are concerns that an individual lacks the capacity to make a decision in relation to their care leaving hospital this must be assessed in accordance with Mental Capacity Act (2005) Code of Practice and recorded appropriately.

Best interest decisions must be based on the decision needed to transfer the care safely as capacity may improve outside of an acute environment.

Decisions made in a person's best interest must consider fully the expressed current and former wishes of the individual, even if these are considered unwise, involve any family or other important person in the individual's lives and be the least restrictive option. Any transfer to residential or nursing care when the person is unable to consent constitutes a deprivation of liberty (DoLs) and this must be considered as part of the best interest decision.

If there are no family members available, then an Independent Mental Capacity Act Advocate (IMCA) should be consulted.

If a family member has power of attorney for health decisions this is only relevant if the person lacks capacity and evidence of this must be provided.

The lead professionals within the ToCH will typically be involved in the discharge of people with complex needs and can provide expert advice and support to ward staff and managers to develop appropriate plans.

4.10 Housing

If a person is unable to return to their own home due to housing related issues and is at risk of becoming homeless then under the Homelessness Reduction Act 2017 the ToCH will undertake a duty to refer to the relevant housing department. (Links can be found on intranet page).

The referral must be discussed with the individual involved and can be submitted to the Council Housing Department of their choice; however, the individual should be informed that local areas will prioritise people who have a local connection. Please see appendices for local protocols

The suitably of a person's home environment should be considered as part of the discharge planning process and if required appropriate referrals made. Referrals are to be facilitated by the professional completing the assessment.

Please see procedure - Transfer of Care Pathways and Processes - for local housing contact information and guidance.

4.11 Safeguarding Concerns

Adults for whom there may be safeguarding concerns who do not meet the criteria to reside can be discharged as long as:

- The safeguarding concern has been referred to the Local Authority and a decision has been made that the concern does not require a formal safeguarding enquiry response.
- Or the concern does warrant further enquiry and at least one of the following applies:
  - ♦ There is an appropriate safeguarding plan in place
  - ♦ Further enquiries can reasonably be undertaken following discharge as part of an initial safeguarding plan or risk assessment
  - ♦ The individual has the capacity to understand the safeguarding concern but chooses not to remain in hospital and a risk plan has been agreed by the adult and health and social care system partners.

For safeguarding concerns where these conditions cannot be met the individual should remain in hospital and multi-disciplinary discharge planning should take place based on the principles of making safeguarding personal. These individuals will remain medically optimised.

Multi-disciplinary meetings will be arranged, as appropriate, by colleagues providing support to the person.

Individuals should not remain in hospital for any longer than is necessary to put the appropriate safeguarding plans in place.

4.12 Repatriation to other Trusts or Out of County Care Facility

People requiring repatriation to another acute/community trust which is not deemed to require an emergency response due to immediate risk of serious injury or death, should be referred to the ToCH for transfer arrangements to be made, including securing funding for transfer through the appropriate local health and social care system.

Transfer of Care Hub team members will liaise with patient flow colleagues as appropriate.

4.13 Transfers from Mental Health Hospitals / Assessment and Treatment Units

Transfers of care from mental health hospitals fall out of the scope of the national Hospital Discharge and Community Support Guidance.

However, systems are encouraged to consider embedding the principles of discharge to assess adapted for mental health care pathways.

In Morecambe Bay we will ensure people who require support to transfer from a mental health hospital will have access to physical health services such as pathway one discharge to assess services and community hospitals. Support to navigate access to these will be provided by the Transfer of Care Hub.

4.14 Discharges

People must be supported to leave hospital as early as possible when they no longer meet the Criteria to Reside - national guidance notes patients should leave hospital within 2 hours when they do not meet criteria to reside. Individuals, their carers, families, friends, and relevant care and support agencies will be advised of the expected timing of discharge.

A discharge summary will be provided with any take home medication required.

Discharge plans will only be cancelled in exceptional circumstances. If a discharge is cancelled then the ward must let the individual, any family or friends and care providers know at the earliest stage.

Detailed guidance can also be found in the Lancashire & South Cumbria Hospital Discharge Standard Operating Procedure.

4.15 Pathway 0

Ward based clinicians are responsible for the discharge of all people on pathway 0, however the Transfer of Care Hub can provide some support such as arranging transport (if all other transport options have been considered and exhausted) or involvement of voluntary agency support where it would be beneficial (such as for help in applying for benefits).

People will be categorised as on pathway 0 when they do not require ongoing interactions with health or social care services to support recovery, although they may need a limited number of arranged follow ups immediately after discharge (for example, the removal of stitches in a clinic setting or at home). Referrals to the relevant services should be made prior to discharge.

Avoiding delays to discharge and improving outcomes for individuals is imperative. For people on Pathway 0 this needs to be within one hour of that decision being made, transferring from the ward to the Priority Assessment and Discharge Unit (PADU) / discharge area promptly to await take home medication (TTO's), Discharge Summary letters and equipment.

4.16 The Transfer of Care Hub (ToCH)

The Transfer of Care Hub (ToCH) is a service model which has been developed to implement an expert complex multi-disciplinary and inter-disciplinary discharge team, working in a seamless and integrated way across partner organisations, both health and social care.

The Hub model in Morecambe Bay is based on a hybrid approach, with some colleagues having a physical presence in the hub and other wider system partners linked virtually. This approach supports the very large geographical area of Morecambe Bay, and maximises resources.

The ToCH will proactively seek, case manage and support a range of people with complex discharge needs and progress these people safely to transfer / discharge via an appropriate pathway (discharge pathways 1-3 - please see 4.19 - 4.21 for further information).

For further details regarding discharge pathways and links to specialist care providers, please see procedure - Transfer of Care Pathways and Processes.

4.17 Transport

Only people who meet the eligibility criteria will be accepted on the Non-Emergency Patient Transport Service. For further details please see the UHMB Transport Booking Procedure (see section 6).

When transport is required, to ensure home assessment slots are met, transport should be booked in advance of the arranged discharge.

Discussions with the person and their family / carers will be required to ensure, where possible, they make their own transport arrangements.

4.18 Continuing Health Care (CHC)

NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding individuals, have to be assessed by integrated commissioning boards (ICBs) according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.

CHC can by provided on discharge pathways 1, 2 or 3.

Asessment is completed by the Transfer of Care Hub team at RLI and on behalf of the FGH team by Home Select (a service funded by the ICB).

4.19 Transfers of Care – Pathway 1

Pathway 1 relates to people being discharged with home-based provision of health or social care support in line with the principles of "no place like home". All people needing new health and care support should be offered reablement and rehabilitation and, where necessary, time for assessment and future care planning post reablement/rehabilitation.

This pathway should also include people whose homecare package is being restarted after lapsing during their hospital stay.

People identified on Pathway 1, deemed medically optimised and no longer meeting the criteria to reside should have plans put in place to leave on the same day as this decision is made.

This pathway will include Fast Track discharges home.

Consideration must be given to maximising the use of technology enabled care, voluntary sector support and any carers support to support a pathway one discharge.

Please see Appendix 1 - Pathway Definitions: Lancashire & South Cumbria and procedure - Transfer of Care Pathways and Processes - for Pathway 1 process charts.

4.20 Transfers of Care – Pathway 2

Pathway two supports people who require ongoing therapy that can only be provided within a 24-hour bedded facility.

People on pathway 2 may require a transfer to a short-term bed within a residential/nursing setting for ongoing care assessments which cannot be facilitated safely within the persons previous place of residence.

If a transfer is necessary, this must not happen without involvement from the local authority.

Transferring a person to a pathway two bed is a complex process and the appropriate process must be followed considering mental capacity act requirements.

The ToCH will be responsible for identifying and case managing all pathway 2 referrals within the acute hospital ensuring all system partners are involved in any discussions and decision making. Efforts should be made to source a transfer of care bed close to a person's home and if outside of the persons GP area appropriate GP cover will need to be in place prior to the transfer taking place.

Please see Appendix 1 - Pathway Definitions: Lancashire & South Cumbria and procedure - Transfer of Care Pathways and Processes - for Pathway 2 process charts.

4.21 Transfers of Care – Pathway 3

System partners should work towards an ambition whereby no person is transferred to a care home as a permanent placement for the first time straight from an acute hospital bed. If a transfer is necessary, this must not happen without involvement from the local authority.

People on pathway 3 may require a transfer to a short-term bed within a residential/nursing setting for ongoing care assessments which cannot be facilitated safely within the persons previous place of residence

The ToCH will be responsible for identifying and case managing all pathway 3 referrals within the acute hospital ensuring all system partners are involved in any discussions and decision making. Efforts should be made to source a transfer of care bed close to a person's home and if outside of the persons GP area appropriate GP cover will need to be in place prior to the transfer taking place.

This will also include Fast Track discharge to Hospice and 24-hour care placement.

Transferring a person to a pathway three bed is a complex process and the appropriate process must be followed considering mental capacity act requirements.

Please see Appendix 1 - Pathway Definitions: Lancashire & South Cumbria and procedure - Transfer of Care Pathways and Processes - for Pathway 3 process charts.

4.22 Current Infection Control and Prevention Guidance

For people being supported on pathway 2 or 3, if they are within 90 days of a positive PCR test a negative LFT test is required prior to leaving hospital.

If the person has not had COVID-19, or it is longer than 90 days since they had a positive PCR, a negative PCR test is required prior to leaving hospital.

For people being supported on pathway 1, if they live with a vulnerable person, wards colleagues will liaise to ensure appropriate safety procedures are followed, and community guidance followed.

Please note - in all circumstances the latest safety guidance should be followed at all times.

4.23 Priority Assessment and Discharge Unit (PADU)

PADU, at the Royal Lancaster Infirmary, ensures a smooth transition from ward to discharge for patients in our care on the day of their discharge.

The unit will provide a safe, comfortable environment where patients can wait to be discharge, whilst preparations are being finalised.

This will allow beds to be vacated earlier in the day to facilitate the admission of acutely ill patients. The Unit will facilitate an environment which is more conducive in providing medication counselling. It will also enable a more central pick-up point for North West Ambulance Service / relatives.

Patients who are going home on Home First are able to go to PADU and their bed will be available to allow the new patient to timely access this.

Even if the patient is not going to the discharge area (early home first slot) they should still be ‘transferred’ to PADU on Lorenzo so the bed can be available to allow the next patient to be admitted into a bed

If the Home First is unsuccessful, the patient will return to PADU until an appropriate bed is allocated.

4.24 Fast Track / End of Life

The intention of the Fast Track Pathway is that it should identify individuals who need to access NHS Continuing Healthcare quickly, with minimum delay. Therefore, the completed Fast Track Pathway Tool, which clearly evidences that the person has a primary health need arising from a rapidly deteriorating condition and the condition may be entering a terminal phase, is in itself sufficient to establish eligibility. This should follow the Gold Standard Framework.

4.25 Palliative Care

This applies to people with specialist palliative care needs however, input may be from a

single or multi-disciplinary team depending upon the place of discharge. Specialist advice from the palliative care team may be required to ensure prompt access to and availability of equipment or services.

4.26 Hospital Home Care

The Hospital Home Care team (of UHMB) supports the transfer of care of patients on a Home First pathway 1 in South Cumbria. These people may have care or rehabilitation needs at home, whilst their longer-term care arrangements are being established.
The service is intended to support patients at home for up to 5 days - until reablement or longer-term care can be facilitated.

4.27 Intermediate Care Allocation Team (ICAT) North Lancashire

The ICAT provides a single point of access to health and social care professionals throughout North Lancashire, offering direct access to a range of intermediate care resources provided by Lancashire County Council, as well as other specifically commissioned services within the voluntary sector. Please see North Lancashire pathways and locality support, within the procedure - Transfer of Care Pathways and Processes - for further details about ICAT support for transfers of care.

4.28 Ensuring Quality of Transfer of Care

We are committed to:

- Providing clear information at all stages of acute hospital stay
- Following the basics of good discharge, people go home with their own property, with medications and at a reasonable time of the day
- Making sure the planned discharges take place unless the person becomes unwell
- Ensuring that transfers of care to other providers are accompanied by accurate up to date information relevant to the person being transferred
- Improving the understanding of discharge to assess across our staff and our communities
- Working with our communities to understand and manage expectations
- Ensuring every person who is discharged has a named professional who knows about the persons medical care plan and can discuss this with individuals carers and families.
- Fostering a learning environment that is open to feedback and tackles issues

And to ensure we do not:

- Allow the person to get lost in the overall pressure of day-to-day operations
- Move people to other wards, hospitals, or care homes without a discussion with individuals and their families / carers
- Keep people in hospital when they want to, and could, go home

4.29 Escalation Process and Surge Plans

The A&E delivery board is the system channel for managing escalation and flow and any partner organisation can request escalation support as requested.

System escalation should be used appropriately and proportionately, and measures kept under review through the agreed surge plan.

Long length of stay meetings, Multi Agency Discharge Event (MADE) and Complex Case meetings provide additional capacity for more in-depth multi-disciplinary discussion in addition to the daily flow meetings. The frequency of these meeting will be reviewed in line with system pressures.

Escalation level	Actions
OPEL 1 Business as usual	• Maintain focus on safe patient flow • Escalate internal issues to the Operations Room ext. 42248 • Active monitoring of infection control issues • Maintain timely communication with system partners • Proactive public communication strategy • Maintain routine monitoring of external risk factors - weather, community outbreaks, travel etc.
OPEL 2 Moderate pressure	• All OPEL 1 actions implemented and: • Undertake additional ward rounds and maximise rapid discharge of patients including use of Discharge Lounge & PADU • Clinicians to prioritise discharges • Activate escalation beds where staffing levels allow • Maximise use of nurse led wards and discharges • Consideration of cancelling elective activity in order to reduce bed pressures • Escalate all patients waiting >48hrs to repatriate to home area • Clinical Matrons supporting wards to expedite discharges
OPEL 3 Significant pressure	• All OPEL 2 actions implemented and: • ED senior clinical decision maker to be present in the department 24/7 where possible • Contact all relevant on-call staff and ensure briefed and asked to support as required • All escalation beds opened and staffed • CSM/Clinical Operations Managers/Infection Prevention & Control undertaken side room audit against priority matrix • Agree with COO/Chief Nurse/Medical Director use of Full Capacity Protocol • Review training and admin shifts and determine if re-deployment of staff supports • Consider internal divert between EDs and UTC • CCG led daily system meeting to escalate issues and required actions • Review all non-essential meetings and determine what still need to go ahead • Matrons & Clinical Service Managers assigned wards to ensure support for discharges and escalation of issues impacting flow

	• Weekly MADE events led by DCOO • Increase private ambulance capacity to expedite faster discharges • Review staffing for next 48 hours redistributing as necessary to make all areas safe and support escalation beds • Review all diagnostic activity and prioritise inpatient activity • Review all outpatient activity and determine if staff could be redeployed
OPEL 4 Intolerable pressure	• All OPEL 3 actions implemented and: • Strategic on-call based in the Command Centre • Discuss with NWAS and ICS Trusts potential for formal diverts • Daily system call chaired by COO, Strategic on-call (weekends)and attended by Director level • Review all elective activity and determine if additional emergency bed capacity can be created through cancellation • Notify ICS and NHSE of escalation ensuring form is submitted in a timely manner • All non-essential meetings cancelled • Consider cancellation of leave and calling staff back to work • AEDB partners briefed and asked to implement their OPEL 4 actions • Strategic and Tactical on-call work from Command Centre whilst on site • Consider if additional MADE events are required • Consider requirements to have on-call consultants present on site overnight • Cancel non-urgent elective activities including both out-patients and inpatients

Please refer to Managing Patient Flow, Surge and Escalation Plan (see section 6)

5. ATTACHMENTS

Number	Title	Separate attachment
1	Pathway Definitions: Lancashire & South Cumbria	N
2	Monitoring	N
3	Values and Behaviours Framework	N
4	Equality & Diversity Impact Assessment Tool	N

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS

The latest version of the documents listed below can all be found via the Trust Procedural Document Library intranet homepage.

Unique Identifier	Title and web links from the document library
Corp/Proc/103	Transfer of Care - Pathways and Processes Procedure
Corp/Proc/094	UHMB Transport Booking Procedure
Not yet live	Managing Patient Flow, Surge and Escalation Plan
Corp/SOP/062	Supporting Patient Choices to Avoid Long Hospital Stays

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
Every effort been made to review/consider the latest evidence to support this document?	Yes
If 'Yes', full references are shown below:	

Number	References
1	Department of Health and Social Care (2022) Hospital Discharge and Community Support Guidance [Online] Available from: https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance (accessed 10/10/2022)
2	Health and Care Act (2014) Hospital Patients with Care and Support Needs [Online] Available from: https://www.legislation.gov.uk/ukpga/2022/31/section/91/enacted (accessed 09/12/2022)
3	The Mental Capacity Act (2005) [Online] Available from: https://www.legislation.gov.uk/ukpga/2005/9/contents (accessed 09/12/2022)
4	The Mental Capacity (Amendment) Act (2019) [Online] Available from: https://www.legislation.gov.uk/ukpga/2019/18/enacted (accessed 09/12/2022)
5	Managing Transfers of Care – A High Impact Change Model: Changes 1-9 (2020) [Online] Available from: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high (accessed 09/12/2022)
6	Top tips for implementing a collaborative commissioning approach to Home First [Online] Available from: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/hospital-discharge/guidance/top-tips (accessed 09/12/2022)
7	Implementing the Home First Discharge Policy [Online] Available from: https://www.local.gov.uk/our-support/sector-support-offer/care-and-health-improvement/system-transformation-and-16 (accessed 09/12/2022)
8	Discharge Policy Implementation: Transfer of Care Hubs – Good Practice Guide - Integration and Better Care Fund (2022) (PowerPoint Presentation)

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
CHC	Continuing Health Care (a funding stream for NHS care out of hospital)
CTR	Criteria to reside
DOLS	Deprivation of Liberty Safeguard
EDD	Estimated Discharge date
FGH	Furness General Hospital
ICB	Integrated Care Board
RLI	Royal Lancaster Infirmary
MADE	Multi Agency Discharge Event
MAR	Medication administration record
MDT	Multi-disciplinary team
NHSE/I	National Health Service England/Improvement
NWAS	North West Ambulance Service

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
NWPALS	North West Private Ambulance Liaison Services
PADU	Priority Assessment and Discharge Unit
PES	Patient Emergency Services
PTS	Patient Transport Services
SAFER	**S**enior review before midday, **A**ll patients have EDD date, **F**low from admission units to wards to start by 10am **E**arly discharge, multi-disciplinary **R**eview (over 7 days)
SDEC	Same day emergency care
SOP	Standard operating procedure
STRATA	Referral system for social care activities including short term services and follow up assessments
TOC	Transfer of care
ToCH	Transfer of Care Hub
TTO	To take out (medications to take home from hospital)
WGH	Westmorland General Hospital

9. CONSULTATION WITH STAFF AND PATIENTS		
During the development of this procedure, and during the development of the associated Transfer of Care Policy and Procedures, colleagues from the following organisations have been consulted in a number of ways - including via email, at focused meetings, at Transfer of Care Hub workstream development meetings (held fortnightly) and at Morecambe Bay Discharge Steering Group meetings (held fortnightly). Drafts of the documents were also shared with stakeholders for review and comment, via email, on 30/8/2022.		
Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name/Meeting	**Job Title**	**Date Consulted**
University Hospitals of Morecambe Bay NHS Foundation Trust Cumbria County Council Lancashire County Council Cumbria Care NHS Lancashire and South Cumbria Integrated Care Board North West Ambulance Service		At fortnightly Transfer of Care Hub development meetings and Morecambe Bay Discharge Steering Group Meetings (since October 2021)
North Yorkshire County Council Barrow Borough Council Lancaster City Council, South Lakeland District Council Lancashire and South Cumbria NHS Foundation Trust St. John's Hospice St. Mary's Hospice Voluntary sector organisations (including commissioned voluntary sector services)		During focused meetings - and via email on 30/8/2022

10. DISTRIBUTION & COMMUNICATION PLAN	
Dissemination lead:	Dee Houghton - Deputy Chief Operating Officer

10. DISTRIBUTION & COMMUNICATION PLAN	
Previous document already being used?	No
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News. New documents uploaded to the Document Library.

11. TRAINING

Is training required to be given due to the introduction of this procedural document? **Yes**

If 'Yes', training is shown below:

Action by	Action required	To be completed (date)
Transfer of Care Hub	Ongoing training and development for colleagues involved with supporting transfers of care.	Ongoing

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Section/Page Changed**	**Description of Change**	**Review Date**

Appendix 1: Pathway Definitions – Lancashire & South Cumbria

Pathway Definitions: Lancashire & South Cumbria

If a person in hospital does not meet the Criteria to Reside (Annex A Hospital Discharge Service: Policy & Operating Model 21.8.2020) they must be discharged as soon as they are clinically safe to do so. [s2.3]
Discharge to Assess will be the default option for everyone who requires an assessment of their care needs.
At least 95% of people leaving hospital should be going straight home or returning to their usual place of residence, either on Pathway 0 or Pathway 1**.**

[***s3.1 NB the national policy is based on data relating to over 65s, but the principle applies to all adults and as an ICS we will be reporting on adults 18+)***

The most appropriate pathway for the person is determined by their needs, and the anticipated potential outcome. There will be people who have complex or complicated needs and health or social care could be responsible for the discharge, case management and funding of those people in any of the pathways.

Important considerations for all pathways:

Mental Health
• For people where new mental health concerns are considered in light of discharge, psychiatric liaison teams should be contacted by case managers in the first instance to review and assess as appropriate.
• For people with a pre-existing mental health concern who are known to mental health services, their care coordinator or relevant mental health clinician should be involved in their discharge planning to ensure their mental health needs are considered as part of this.

Mental Capacity
• Duties under the Mental Capacity Act 2005 still apply during this period. DHSC has published emergency guidance for health and social care staff in England and Wales who are caring for or treating a person who lacks the relevant mental capacity during the COVID-19 pandemic.
• If there is a reason to believe a person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, capacity assessments should be carried out before decisions about their discharge are made. Where the person is assessed to lack the relevant mental capacity and a decision or decisions need to be made, then there should be a best interests decision/s made for their ongoing care in line with the usual processes. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes and orders from the Court of Protection for community arrangements still apply or the Liberty Protection Safeguards when these have replaced them.

End of life care

For people identified as being in the last days or weeks of their life, the single point of access will be responsible for overseeing communication with primary care, community services and, where required, community palliative care services to coordinate and facilitate rapid discharge to home or hospice.

Homelessness
All persons who are homeless or at risk of homelessness on discharge should be referred by acute hospital staff to local authority homelessness/housing options teams, under the requirements of the Homelessness Reduction Act (2017) (see Homelessness chapter). This duty to refer ensures that peoples' housing needs are considered when they come into contact with public authorities. Further guidance on supporting homeless persons in hospital discharge can be found in the High Impact Change Model for Managing Transfers of Care (Local Government Association).

Pathways: Pathway	**Includes**
Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.	This pathway is led by the Acute Trusts and are those discharges for people who are considered to be well enough for self-care upon discharge. • • The pathway may include a limited number of arranged follow ups (for example, the removal of stitches in a clinic setting or at home). However, this pathway should not include ongoing care. • • Voluntary sector services can also be used to support discharge and prevent further admissions to hospital. • • Domiciliary care restarts (regardless of existing funding route including health/social care/self-funded/personal heath budget/social care direct payment) **where care needs remain unchanged and the care remains available** (irrespective of who facilitates the restart)

Discharge to assess pathways 1-3 require NHS organisations to work closely with adult social care and housing colleagues, the care sector and the voluntary sector. To ensure that resources are used effectively across the system, acute trusts should ensure that their staff work closely with community health services and local authorities on pathways 1-3.

Information essential to the continued delivery of care and support must be communicated and transferred to the relevant heath and care partners on discharge. This **must** include, where relevant, the outcome of the last COVID-19 test.
No-one should be discharged from hospital directly to a new care home placement (including all categories in pathways 2 and 3)

without the involvement of the local authority, regardless of the funding route.

Pathway 1
45% of people – support to recover at home; able to return home with support from health and/or social care.

This pathway is led by the health and social care teams working together and includes:

- • Home First – in all its forms i.e. with or without a therapist on the day of discharge (includes 'home to assess')
- • People returning home with support needs for up to 6 weeks of recovery support from health and/or social care to maximise their independence – new or enhanced needs are funded for this period from the Discharge Support Fund
- • Physio or Occupational Therapy to aid recovery and maximise independence
- • Integrated Community Stroke Team - early intensive intervention
- • Reablement
- • Enablement (Learning Disabilities)
- • Age UK / Red Cross Take Home and Settle service
- • Short term Live-In care
- • Rapid Response / Crisis care
- • Hospital Homecare
- • COVID Virtual ward
- • Fast Track if returning to own home or existing care home
- • Hospice at Home

There are important differences to how pathways 2 and 3 are defined compared to the previous ways of working across Lancashire & South Cumbria. The following information is to aid interpretation:

- • Everyone should be considered for the opportunity for rehab and/or recovery first
- • Discharge to assess beds can be in both Residential and Nursing Homes
- • For Pathway 2, the important point is that the Care Act and/or eligibility assessment for CHC has not yet taken place, therefore the outcome for the person is not yet determined
- • Pathway 3 includes scenarios where the person's needs have been fully assessed and long-term care is arranged directly from hospital e.g.
- - This *may* include situations where the person has been admitted from a Care Home but whose needs have changed and they now need Nursing Home level care (it is important to ensure that where there may be rehab or recovery needs that mean the person could still return to residential level care, this still takes place prior to any decision being made).

Pathway 3 may also be appropriate for people who have had a catastrophic episode and their needs are known, assessed and will not change.
- Pathway 3 may also be the relevant pathway for people who are admitted from a Care Home but the Care Home identifies the person cannot return, so a new placement needs to be sourced however the person's needs are already known and there are no significant changes.

Pathway 2

4% of people – rehabilitation, recovery or short-term care in a 24-hour bed-based setting.

- • Bed based residential rehabilitation and recovery
- • Community hospital / nurse led rehabilitation and recovery
- • D2A in a Nursing Home
- • D2A in a Residential Care Home
- • Short term bed in a Hospice (where the aim is to return home)
- • Fast Track to an interim residential or nursing care home (where the aim is to return home)
- • Short term recovery in extra care/neighbourhood flats etc.

Pathway 3:

1% of people – there has been a life changing event and long-term care is required, usually in a 24hr bed based setting.

This pathway is for those people where it is very clear that at the point of leaving hospital they are likely to remain in long term care (regardless of the funding pathway, however will often be CHC or require a consideration for CHC).

- • Residential Care Home
- • Nursing Care Home
- • Return to existing Residential or Nursing Home **where care needs remain unchanged** (irrespective of who facilitates the restart)
- • Designated Setting bed (included in the national data return in this category, although it remains an interim bed. Onward pathway could include D2A bed, existing care home, return home) for the isolation period required
- • Fast Track to Residential or Nursing Care Home (no likelihood of return home)
- • End of Life care in a Hospice (no likelihood of return home)

Appendix 2: Monitoring

Section to be monitored	Methodology (incl. data source)	Frequency	Reviewed by	Group / Committee to be escalated to (if applicable)
1.Changes to the Hospital discharge and community support guidance (2022) and other relevant health and social care policy and / or statute that may require non substantial changes	To be reviewed as required by the Deputy Chief Operating Officer for Community Services in conjunction with nominated Executive Directors	As required	Relevant Executive Director	Morecambe Bay Discharge Steering Group
2. Organisational structural changes – e.g. changes to Council through LGR that may require title changes etc. And changes linked to Integrated Care Board development	To be reviewed as required by the Deputy Chief Operating Officer for Community Services in conjunction with nominated Executive Directors	As required	Relevant Executive Director	Morecambe Bay Discharge Steering Group
3. That all associated standard operating procedures are in place and remain up to date	To be reviewed as required by the Transfer of Care Hub manager in conjunction with system partners	As required		Morecambe Bay Discharge Steering Group
4. Cross organisational version control (as a consequence of 1, 2 & 3)	To be reviewed as required by the Transfer of Care Hub manager in conjunction with system partners	As required		Morecambe Bay Discharge Steering Group

Appendix 3: Values and Behaviours Framework

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a positive workplace culture. By following our own policies and with our **ambitious** drive we can cultivate an **open, honest and transparent culture** that is truly **respectful and inclusive** and where we are **compassionate** towards each other.

Appendix 4: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Transfer of Care Hub	
Lead Assessor	Dee Houghton	
What is being assessed?	Transfer of Care Hub	
Date of assessment	1/11/2022	
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Network for Inclusive Healthcare?	NO
	Staff Side Colleague?	NO
	Service Users?	NO
	Staff Inclusion Network(s)?	NO
	Personal Fair Diverse Champions?	NO
	Other (including external organisations): *Transfer of Care Hub Workstream *Health and social care system partners from Cumbria, Lancashire and North Yorkshire - including statutory and voluntary sectors	

1) **What is the impact on the following equality groups?**

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination / harassment / victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Positive	The Transfer of Care Hub will facilitate person centred care - working with specialist support providers
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	Due to service provision to support the model - the Transfer of Care Hub model will support all adults (aged 18 +)
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. carers, veterans, people from a low	Positive	Support for carers and veterans will be championed by

socioeconomic background, people with diverse gender identities, human rights)		the Transfer of Care Hub - with links to specialist local support providers developed.

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review once approved/noted by Trust Procedural Document Group.
For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.