Document Type: **Procedure**	**Unique Identifier:** CORP/PROC/103
Document Title: **Transfer of Care – Pathways and Processes**	**Version Number:** 2
	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 Durdu - Discharge Lead Across Bay	**Responsibility:** Transfer of Care Hub
Replaces: Version 2, Transfer of Care – Pathways and Processes, Corp/Proc/103	**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 Lynne Wyre, Deputy Chief Nurse Discharge Steering Group	**Date:** 01/12/2022
Ratified By: Trust Procedural Documents Group	**Date:** 13/09/2023
Review dates may alter if any significant changes are made	**Review Date:** 01/12/2025

- 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 – Pathways and Processes is the local procedure to support delivery of -the national Hospital Discharge and Community Support Guidance.

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

This procedure, together with the Transfer of Care Policy, supports the transfer of care from the Acute hospitals to the community.

The procedure 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 procedure (team members from the RLI also support transfers of patient care from the Westmorland General Hospital).

The principles of this procedure 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 Procedure 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)[1]
  - The Care Act (2014)[2]
  - The Mental Capacity Act (2005)[3]
  - The Mental Capacity (Amendment) Act (2019)[4]

- Should be considered in conjunction with:
  - Pathway Definitions: Lancashire & South Cumbria (please see appendix 1 of Transfer of Care Policy)

The principles of this procedure 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 procedure 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 procedure, and accompanying policy, 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 (Westmorland and Furness, Cumberland, 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 procedure and the delivery of the elements of the procedure 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, Westmorland and Furness Council • Director of Adult Social Care Services, Cumberland 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 procedure 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. • Ensuring 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. • Recognising 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 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 • Provide a case management function for people with complex discharge planning requirements. • Lead 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 procedure 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 persons progress (diagnostics, tertiary opinion, referrals) to be reviewed and escalate
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 procedure within their organisational scheme of delegation • Escalation of any issues that arise in the delivery of this procedure 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, Westmorland and Furness Council, Cumberland Council Lancashire County Council North Yorkshire County Council Cumbria Care NHS Lancashire and South Cumbria Integrated Care Board Lancaster City Council, Northwest 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. PROCEDURE

4.1 Pathways and Processes

Please refer to the pathways and processes in the appendices.

5. ATTACHMENTS		
Number	**Title**	**Separate attachment**
Appendix 1	Westmorland and Furness Pathway Process Charts	Y
Appendix 2	North Lancashire Pathway Process Charts	Y
Appendix 3	North Yorkshire Pathway Process Charts	Y
Appendix 4	Return to Care Home Existing Residential / Nursing – Care Needs Unchanged	Y
Appendix 5	End of Life (Fast Track)	Y
Appendix 6	Transfer of Care to Hospice Support (St. John's or St. Mary's)	Y
Appendix 7	Support Across Morecambe Bay	Y
Appendix 8	Admission Avoidance Support	N
Appendix 9	Westmorland and Furness Locality Support Part 1	N
Appendix 10	Westmorland and Furness Locality Support Part 2	N
Appendix 11	North Lancashire Locality Support	N
Appendix 12	North Yorkshire Locality Support	N
Appendix 13	Monitoring	N
Appendix 14	Values and Behaviours Framework	N
Appendix 15	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/Pol/198	Transfer of Care Policy
Corp/SOP/062	Supporting Patient Choices to Reduce 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 10/10/2022)
3	The Mental Capacity Act (2005) [Online] Available from: https://www.legislation.gov.uk/ukpga/2005/9/contents (accessed 10/10/2022)
4	The Mental Capacity (Amendment) Act (2019) [Online] Available from: https://www.legislation.gov.uk/ukpga/2019/18/enacted (accessed 10/10/2022)
5	Managing Transfers of Care – A High Impact Change Model: Changes 1-9 (2020)

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
	[Online] Available from: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high (accessed 10/10/2022)
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 10/10/2022)
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 10/10/2022)
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
EDD	Estimated Discharge date
EPR	Electronic Patient Record
FGH	Furness General Hospital
ICB	Integrated Care Board
MADE	Multi Agency Discharge Event
PADU	Priority Assessment and Discharge Unit
PTS	Patient Transport Services
RLI	Royal Lancaster Infirmary
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)
SOP	Standard operating procedure
STRATA	Referral system for social care activities including short term services and follow up assessments
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, 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 and at Morecambe Bay Discharge Steering Group meetings. Drafts of the documents were also shared with stakeholders for review and comment, via email, on 30/8/2022 and 15/3/2023.

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 Westmorland and Furness Council Cumberland Council Lancashire County Council Cumbria Care NHS Lancashire and South Cumbria Integrated Care Board Northwest Ambulance Service		At Transfer of Care Hub development meetings and Morecambe Bay Discharge Steering Group Meetings (since October 2021)
North Yorkshire County Council Lancaster City 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
Integrated Community Care Group		20/04/2023
Medicine Documents Group		04/05/2023
Surgery and CC		09/09/2023

10. DISTRIBUTION & COMMUNICATION PLAN

Dissemination lead:	Sharon Durdu
Previous document already being used?	Yes
If yes, in what format and where?	Trust Procedural Document Library
Proposed action to retrieve out-of-date copies of the document:	Contact Policy Coordinator
To be disseminated to:	All staff
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

1	09/11/2022		New document	01/04/2023
2	13/09/2023	Front page	Removed Tracy Ashton	01/12/2025
		Front page	Name change for Sharon Doyle to Sharon Durdu	
		Section 1	Removed Italics in summary	
		Section 3.1	Removal of previous council names and replaced with new council names	
		Appendix 1	New Pathway 1 – Westmorland and Furness added	
		Appendix 2	New Discharge to Assess Pathway 1 - North Lancashire added	
		Appendix 8	Additional appendix added	
		Page 41	Email address updated	
		Page 47	Email address updated	
		Page 50	Email address update	

Appendix 1: South Cumbria Pathway Process Charts

Link to printable version: Transfer of Care - South Cumbria Pathway Process Charts.docx

Pathway 1 –Westmorland and Furness and Cumberland

Patient conversations and MDT discussion - Pathway 1 agreed
Decision made to follow Home First pathway (patient taken home to assess)

Referral made to Hospital Administration team - via STRATA

Complex Case Manager (CCM) completes triage to ensure appropriateness of pathway

If patient may have complex needs - consider early referral to social worker

Discharge Team book first available home visit slot and transport - Discharge Coordinator confirms details with patient's family / friends / carers

If patient has existing package of care - can be restarted at this point

Ward arranges TTOs and any medical sundries required

Patient collected from ward / PADU - by family members or transport

If during transportation, the patient becomes acutely unwell with any new symptoms, professional to risk assess the patient and transfer to ED if deemed appropriate

Patient met at their home by OT

Following successful OT assessment - OT informs Hospital Home Care (HHC) Team of care need information

If OT assessment unsuccessful - patient returns to hospital for further assessment. (Consider step up to intermediate care beds)

If during Home First assessment, the patient becomes acutely unwell with any new symptoms, professional to risk assess the patient and contact 999 for transfer to ED if deemed appropriate

HHC support provided in patient's home - onward referral to reablement or mainstream care as appropriate

Day 3 review by Reablement or Short Term Interventions Team (CCC)

HHC service to provide up to 5 days of support

If Reablement is required - HHC liaises with Reablement Review Officer

If Long Term Support is required - once Care Act Assessment has been completed, a requirement will be created on SProc.net

Day 6 onwards - any ongoing support needs (e.g. Reablement or Package of Care) in place

Reablement Discharge Pathway

Trusted Assessor will triage referrals from EPR - identifying patients for the Reablement Pathway. Trusted Assessor will also consider opportunities to support stroke patients on reablement pathway. Conversations with patient take place and support agreed.
Trusted Assessor to liaise with the Reablement & Review Officer regarding completing the assessment (time of discharge).
Trusted Assessor will ensure transport is arranged, TTOs are in place and all other preparations for discharge from hospital are made.

Patient known to Adult Social Care

No
Trusted Assessor creates an IAS record and add referral onto IAS with a contact to the Central Business Function Pending Tray for relevant area stating what capacity they are using.

Yes
Trusted Assessor to add referral onto IAS with a contact to the Central Business Function Pending Tray for relevant area stating the RRO who is dealing with the case.

Reablement assessment and plan to be completed.

RRO will review the case in line with the plan and if ongoing support is required they will make a referral into ASC for an Assessment

If no further support is required after Reablement, the Service will end with no ongoing support.

If Long Term Support is required, Adult Social Care will treat this as High priority and complete an assessment within 48 hours. (48 hour timescale will be dependent upon Adult Social Care staff availability).

Once Care Act Assessment has been completed, a Requirement will be created on SProc.net

Pathway 2 –Westmorland and Furness and Cumberland

Patient conversations and MDT discussion - Pathway 2 agreed

Discussions with relevant social workers - about need for 24 hour care

Appropriate professional assesses capacity and care needs. Discharge discussed with patient and family.

Capacity assessment completed and Best Interest completed if appropriate

Options for discharge discussed with patient, family / friends and carers

Further conversations with Social Worker
(Social Worker may suggest Reablement - in this case Reablement support is arranged and further reviews arranged to assess if patient can return home)

Patient consent and documentation of decision
Complex Case Manager - records on EPR
Social Worker - records on IAS

Case Manager makes referral to Care Finders

Care Finders liaise with patient, family / friends and carers

Placement sourced by Care Finders

Pre-assessment - sent to care home (either accepted or declined by care home)

Decision for Discharge - involving patient, family members and Social Worker

Day of Discharge - information sent to Social Worker via IAS - including capacity assessment, Best Interest and all essential information.
(Note - sometimes information can be delayed until day following discharge)

Social Worker is allocated - with Case Manager support

TEMPORARY PLACEMENT - support provided to enable person to return home. Pathway 1 will be followed - and person will return home with appropriate support provided

LONG TERM PLACEMENT - in nursing or EMI care Decision Support Tool (DST) for health will be facilitated in week 2 / 3 - which then allows 7 days to facilitate end of pathway and next steps

Pathway 3 - Residential / nursing care – Westmorland and Furness and Cumberland

Patient conversations and MDT discussion - Pathway 3 agreed

Discussions with relevant social workers - about need for 24 hour care

Appropriate professional assesses capacity and care needs. Discharge discussed with patient and family.

Capacity assessment completed and Best Interest completed if appropriate

Options for discharge discussed with patient, family / friends and carers

Further conversations with Social Worker

Patient consent and documentation of decision
Complex Case Manager - records on EPR
Social Worker - records on IAS

Case Manager makes referral to Care Finders

Care Finders liaise with patient, family / friends and carers

Placement sourced by Care Finders

Pre-assessment - sent to care home (either accepted or declined by care home)

Decision for Discharge - involving patient, family members and Social Worker

Day of Discharge - information sent to Social Worker via IAS - including capacity assessment, Best Interest and all essential information.
(Note - sometimes information can be delayed until day following discharge)

Social Worker is allocated - with Case Manager support

Placement - in nursing or EMI care
Decision Support Tool (DST) for health will be facilitated in week 2 / 3 - which then allows 7 days to facilitate end of pathway and next steps

Appendix 2: North Lancashire Pathway Process Charts
Link to printable version: Transfer of Care - North Lancashire Pathway Process Charts.docx

Discharge to Assess Pathway 1 - North Lancashire

Patient conversations and MDT discussion - Pathway 1 agreed
Decision made to follow Home First pathway (patient taken home to assess)

Discharge Coordinator makes referral to ICAT - via STRATA

ICAT completes triage to ensure appropriateness of pathway - triaging to be completed within 2 hours

Referral is accepted, declined or further information requested

ICAT book first available home visit slot and ward book transport (family / friends, Age UK Lancashire or patient transport) - Discharge Coordinator confirms details with patient's family / friends / carers

Ward arranges TTOs and any medical sundries required

Patient moved to PADU if appropriate

Patient collected from PADU - by family members or transport

If during transportation, the patient becomes acutely unwell with any new symptoms, professional to risk assess the patient and transfer to ED if deemed appropriate

Patient met at their home by OT

Following successful OT assessment - OT informs ICAT of care need information

Crisis Care support provided in patient's home - onward referral to reablement or mainstream care as appropriate

Day 3 review by ICAT

Crisis Care service to provide 3 days of support

Day 3 onwards - any ongoing support needs (e.g. Reablement or Package of Care) in place

If OT assessment unsuccessful - patient returns to hospital for further assessment. (Consider step up to intermediate care beds)

If during Home First assessment, the patient becomes acutely unwell with any new symptoms, professional to risk assess the patient and contact 999 for transfer to ED if deemed appropriate

Pathway 2 - North Lancashire

Patient conversations and MDT discussion - Pathway 2 agreed

Discussions with relevant social workers - about need for 24 hour care

Appropriate professional assesses capacity and care needs. Discharge discussed with patient and family.

Capacity assessment completed and Best Interest completed if appropriate

Options for discharge discussed with patient, family / friends and carers

Further conversations with Social Worker
(Social Worker may suggest Reablement - in this case Reablement support is arranged and further reviews arranged to assess if patient can return home)

Patient consent and documentation of decision
Complex Case Manager - records on EPR
Social Worker - records on LAS

Case Manager makes referral to Care Finders

Care Finders liaise with patient, family / friends and carers

Placement sourced by Care Finders

Pre-assessment - sent to care home (either accepted or declined by care home)

Decision for Discharge - involving patient, family members and Social Worker

Day of Discharge - information sent to Social Worker via LAS - including capacity assessment, Best Interest and all essential information.
(Note - sometimes information can be delayed until day following discharge)

Social Worker is allocated - with Case Manager support

TEMPORARY PLACEMENT - support provided to enable person to return home. Pathway 1 will be followed - and person will return home with appropriate support provided

LONG TERM PLACEMENT - in nsursing or EMI care Decision Support Tool (DST) for health will be facilitated in week 2 / 3 - which then allows 7 days to facilitate end of pathway and next steps

Pathway 3 - Residential / nursing care - North Lancashire

Patient conversations and MDT discussion - Pathway 3 agreed

Discussions with relevant social workers - about need for 24 hour care

Appropriate professional assesses capacity and care needs. Discharge discussed with patient and family.

Capacity assessment completed and Best Interest completed if appropriate

Options for discharge discussed with patient, family / friends and carers

Further conversations with Social Worker

Patient consent and documentation of decision
Complex Case Manager - records on EPR
Social Worker - records on LAS

Case Manager makes referral to Care Finders

Care Finders liaise with patient, family / friends and carers

Placement sourced by Care Finders

Pre-assessment - sent to care home (either accepted or declined by care home)

Decision for Discharge - involving patient, family members and Social Worker

Day of Discharge - information sent to Social Worker via LAS - including capacity assessment, Best Interest and all essential information.
(Note - sometimes information can be delayed until day following discharge)

Social Worker is allocated - with Case Manager support

Placement in nursing or EMI care
Decision Support Tool (DST) for health will be facilitated in week 2 / 3 - which then allows 7 days to facilitate end of pathway and next steps

Appendix 3: North Yorkshire Pathway Process Charts

Link to printable version: Transfer of Care - North Yorkshire Pathway Process Charts.docx

Pathway 1 - North Yorkshire

Patient conversations and MDT discussion - Pathway 1 agreed
Decision made to follow Home First pathway (patient taken home to assess)
Please contact 01535 293701
Please ensure that consideration has been made for restart of previous POC

TAF form North Yorkshire County Council referral form completed by Complex Case Manager

Referral form to be emailed to - NYCC.AGH@northyorks.gov.uk

Assessment to be completed by Craven Hub and care arranged
Ward book transport (family / friends or patient transport) - Discharge Coordinator confirms details with patient's family / friends / carers

Ward arranges TTOs and any medical sundries required

Patient moved to PADU if appropriate

Patient collected from PADU - by family members or transport

Patient met at their home by North Yorkshire County Council

48 hour review completed by Craven Hub Team and consideration given to CHC monitoring Form

Day 3 review

Day 3 onwards - any ongoing support needs (e.g. Reablement or Package of Care) in place

Pathway 2 - North Yorkshire

Patient conversations and MDT discussion - Pathway 2 agreed

Contact number 015395 293701 for discussion relevant social workers - for 24 hour care

Appropriate professional assesses capacity and care needs. Discharge discussed with patient and family.

Capacity assessment completed and Best Interest completed if appropriate

Options for discharge discussed with patient, family / friends and carers

Patient consent and documentation of decision
Complex Case Manager - records on EPR
Social Worker - records on North Yorkshire County Council ICT system

Case Manager makes referral to Care Finders

Care Finders liaise with patient, family / friends and carers

Placement sourced by Care Finders

Pre-assessment - sent to care home (either accepted or declined by care home)

Decision for Discharge - involving patient, family members and Social Worker

For health to health referrals for in Patient bedded rehabilitation - contact Airedale Digital Care Hub - digital.carehub@nhs.net

For information about making referrals to Castleberg Community Hospital, Settle - please see Appendix 11

Day of Discharge - information sent to Social Worker - including capacity assessment, Best Interest and all essential information.
(Note - sometimes information can be delayed until day following discharge)
Forward to - NYCC.AGH@northyorks.gov.uk

Social Worker is allocated

TEMPORARY PLACEMENT - support provided to enable person to return home. 28 day process
Pathway 1 will be followed - and

LONG TERM PLACEMENT - in nursing or EMI care - 28 day process
Decision Support Tool (DST) for health will be facilitated in week

Pathway 3 - Residential / nursing care - North Yorkshire

Patient conversations and MDT discussion - Pathway 3 agreed

Discussions with relevant social workers - about need for 24 hour care

Appropriate professional assesses capacity and care needs. Discharge discussed with patient and family.

Capacity assessment completed and Best Interest completed if appropriate

Options for discharge discussed with patient, family / friends and carers

Patient consent and documentation of decision
Complex Case Manager - records on EPR
Social Worker - records on North Yorkshire County Council ICT system

Case Manager makes referral to Care Finders

Care Finders liaise with patient, family / friends and carers

Placement sourced by Care Finders

Pre-assessment - sent to care home (either accepted or declined by care home)

Decision for Discharge - involving patient, family members and Social Worker

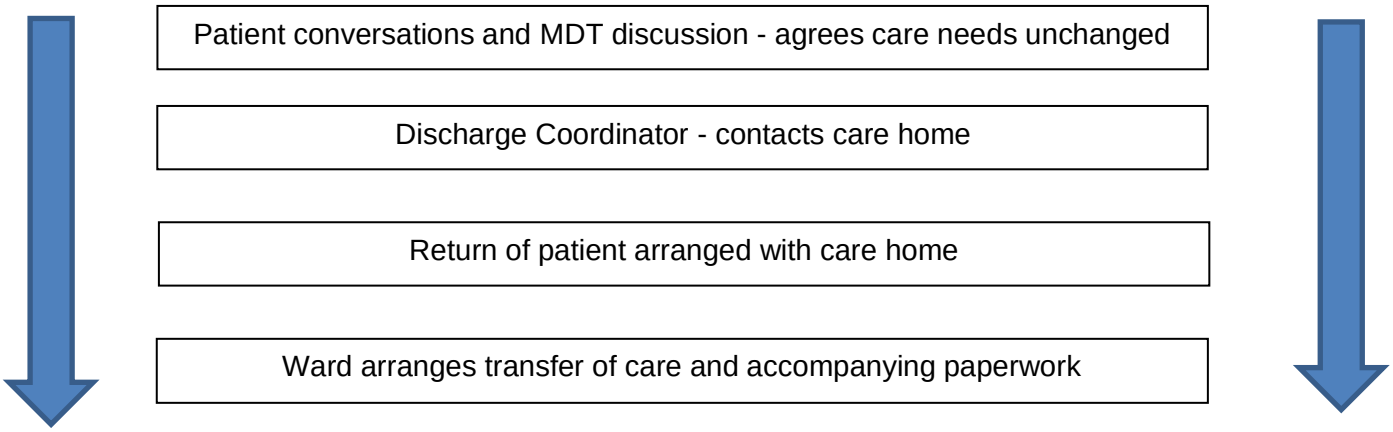
Day of Discharge - information sent to Social Worker - including capacity assessment, Best Interest and all essential information.
(Note - sometimes information can be delayed until day following discharge)
Forward to - NYCC.AGH@northyorks.gov.uk

Social Worker is allocated - with Case Manager support

Placement in nursing or EMI care - Social care team will complete a CHC monitoring form . Decision Support Tool (DST) for health will be facilitated in week 2 / 3 - which then allows 7 days to facilitate end of pathway and next steps

Appendix 4: Pathway 3 - Return to Care Home Existing Residential / Nursing - Care Needs Unchanged

Link to printable version: Transfer of Care - Pathway 3 - Return to Care Home Existing Residential or Nursing - Care Needs Unchanged.docx



Appendix 5: Pathway 3 - End of Life (Fast Track)
Link to printable version: Transfer of Care - Pathway 3 - End of Life (Fast Track).docx

Patient conversations and MDT discussion - Pathway 3 agreed

Case Management Team - agree need for palliative care

Case Manager - completes assessment tool

Conversations with carers, family and friends of patient

Care Finders - search for nursing bed

Costings are established

Cumbria patient - Strata referral made
Lancashire patient - paper form emailed to - mlcsu.dischrge@nhs.net
North Yorkshire (Bentham patients) - Strata referral made
North Yorkshire (Craven area patients) - contact Airedale Digital Care Hub
-
01535-652511 or 01535-292797
digital.carehub@nhs.net

Request submitted for eligibility

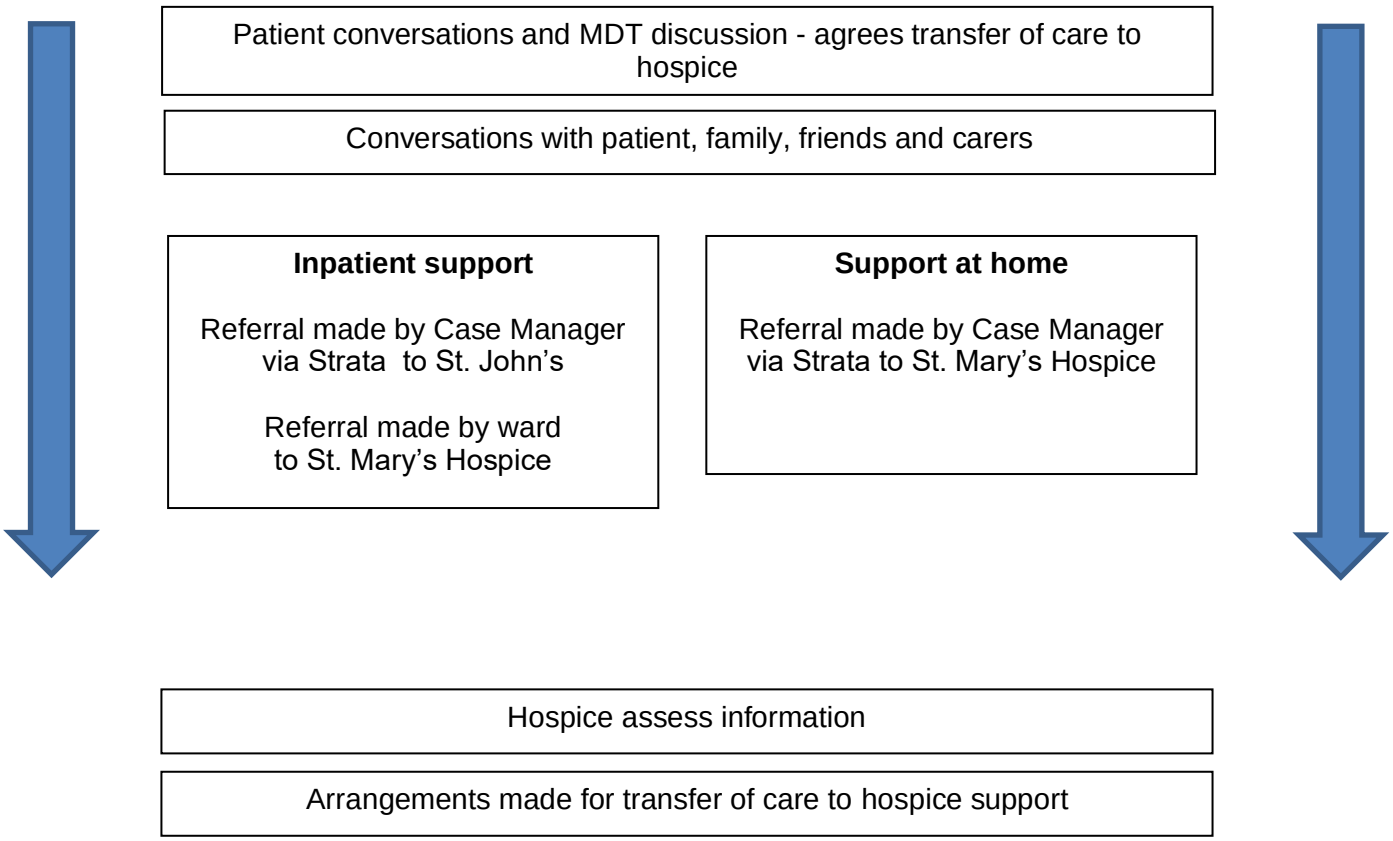
CHC approved and funding confirmed

Ward colleagues book transport

Case Manager confirms details of transfer of care - with carers, family and friends of patient

Transfer of care facilitated

Appendix 6: Pathway 3 - Transfer of Care to Hospice Support (St. John's or St. Mary's
Link to printable version: Transfer of Care - Pathway 3 - Transfer of Care to Hospice Support (St. John's or St. Mary's).docx



Appendix 7: Support Across Morecambe Bay
Link to printable version: Transfer of Care - Support across Morecambe Bay.docx

Transfers of care from Tertiary Care Centres - process chart

Patient is receiving care at tertiary care centre

Patient is medically optimised (also taking account of fitness required for travel to patient's home - which may be considerable journey - particularly to Furness / rural areas of South Lakeland)

Discharge team from tertiary care centre contact UHMB Transfer of Care Hub - **emailing completed Transfer of Care form, via email, to generic Hub email address**

Based on referral form - triage is completed by duty Complex Case Manager

Following triage, patient is allocated a Discharge to Assess slot
(Please note all slots for tertiary care centre patients will be afternoon slots to allow for travel time)

Transfer of Care Hub liaises with ward colleagues at tertiary care centre

Transport to be booked by colleagues at tertiary care centre - ensuring patient will arrive home in time for visit

*** Please note - wait for slot allocation will be dependent upon capacity of Home First slots**

*** If home visit unsuccessful - Occupational Therapist to contact Transfer of Care Hub, who will liaise with Patient Flow Matrons to determine most appropriate support for patient**

Dementia - accessing specialist support

Refer to the UHMB Policy - 'Enhanced Observation, Supervision and Person-Centred Care' - for advice and guidance

Using the Policy - determine the level of Observation and/or Supervision (Enhanced Care) required by the patient

'Starburst' alert may be visible on EPR - also be aware of butterfly icon (as below) on EPR - indicating to check 'Starburst' alert for further support information

If patient requires Level 4 Supervision or above - email Dianne Smith - Matron for Dementia - dianne.smith@mbht.nhs.uk
Tel - 07805895862

Please remember -

***Refer to the UHMB Policy - 'Enhanced Observation, Supervision and Person-Centred Care'- for guidance and support.**

***Contact Dianne Smith If patient requires Level 4 Supervision or above.**

***For specialist advice and guidance - contact Dianne Smith.**

Learning Disability, Autism and Complex Needs - accessing specialist support

‘Starburst’ alert will be visible on EPR for anyone aged over 14, with learning disabilities recorded on GP system

‘Starburst’ alert on EPR will also indicate if the patient has a hospital ‘Passport of Care’ available

Consider Mental Capacity Act requirements - the UHMB Policy ‘Enhanced Observation, Supervision and Person-Centred Care’ can assist

As soon as possible - email Brian Evans - Matron for Learning Disability, Autism and complex needs - even if the patient has returned home - brian.evans@mbht.nhs.uk

Please remember -

*** Always check all EPR ‘Starburst’ alerts.**

*** Always email Brian Evans as soon as possible (even if the patient has returned home) - to ensure appropriate support can be provided for the patient in hospital and to allow follow-up with community teams and GP as appropriate.**

*** Pro-active referral, rather than a reactive referral, can ensure planning for the patient to return home can begin as soon as possible.**

ICC Links

Across Morecambe Bay ICC's have detailed knowledge of local voluntary sector services, available to support people in their local communities.

If it is felt specialist support may be of benefit - the ICC where the person lives should be contacted for specialist advice.

Each ICC also holds regular meetings - which Complex Case Managers attend.

St. John's Hospice

For information please visit -

https://www.sjhospice.org.uk/hospice-care/

Referrals

Referrals for support can be made via Strata or via the referral form -

https://www.sjhospice.org.uk/referrals/

For advice and assistance please call to speak with a St. John's Hospice team member.

Community Services

Day Therapy at St John's Hospice includes a range of groups, Day Hospice, clinics and 1:1 service. Specific group support breathlessness and COPD symptoms.

Day Therapy Services are provided by a team of different professionals, including nursing staff, support workers, complementary therapy staff, volunteers, social work, physiotherapy, family support services and occupational therapy**.**

Hospice at Home

The Hospice at Home team is a dedicated unit of healthcare professionals who visit patients in the comfort of their own home to offer palliative care at the end of life. Offering symptom management, in addition to support and advice, the team help both the patient and their family.

The Hospice at Home team travel as far as Garstang in the south, Sedbergh in the east and Ambleside in the north.

Inpatient Ward

The in-patient unit, with 13 beds, provides specialist palliative care and support for anyone aged 18 years and over.

Patients are supported with symptom management and end of life care.

Bereavement Service

The hospice has a small bereavement service which supports families known to St John's Hospice and specialist palliative care services.

Please get in contact with St. John's Hospice if a child or a young person may need bereavement support.

St. Mary's Hospice

For information please visit -

https://www.stmaryshospice.org.uk/

Referrals

Referrals for support can be made via Strata.

For advice and assistance please call to speak with a St. Mary's Hospice team member.

Hospice Care at Home

A service for people who are identified as being in their last week's / days of life, want to be at home and need support with care needs.

- Have been are assessed by a healthcare professional to be in their last weeks or days of life
- Live in the Furness and South Lakes area
- Are over the age of 18
- Have chosen to die at home

Care will be delivered through this 12-week service between the hours of 7.30am – 10.30pm seven days a week.

All people assessed and accepted on to the service will be supported with a maximum of four care visits per day by two Home Care Assistants and be based on individual need.

In-patient Unit

The unit has 8 beds, with a team of nurses, doctors and other health & social care professionals who specialise in helping people with difficult symptoms, physical pain and emotional distress.

Patients are supported for a variety of reasons - including control of symptoms such as pain or breathlessness, emotional and family support or end of life care.

Support for veterans

Veterans' Gateway
First point of contact for veterans and their families providing information, advice and support. 0808 802 1212 or text 81212 or visit www.veteransgateway.org.uk

SSAFA
Welfare, health and support services, for the UK military's serving personnel, veterans, and their families. 0800 731 4880 or visit www.ssafa.org.uk

Royal British Legion
Welfare, health and support services, for the UK military's serving personnel, veterans, and their families. 0808 802 8080 or visit www.britishlegion.org.uk

NHS Veterans' Trauma Network
Provides specialist care to veterans with physical injuries related to their time in service. www.nhs.uk/nhs-services/armed-forces-community/veterans-service-leavers-non-mobilised-reservists

NHS OP Courage - Veterans' Mental Health and Wellbeing Service
OP Courage is for serving personnel approaching discharge, and for veterans. The service provides a range of treatment, from access to early support, to therapeutic treatment for complex mental health difficulties, and psychological trauma. 0800 652 2867 or email VTILS@cntw.nhs.uk

Should a Veteran like to join a local veterans group to meet other veterans in the area, they can be signposted to -

AFVBC Club Search - https://www.afvbc.net/club-search/

Emergency Services and Armed Forces veterans - FirstLight Trust homepage -

https://www.firstlighttrust.co.uk/

SPACES

SPACES deliver a housing advice and placement service to single veterans who are homeless or threatened with homelessness, throughout the UK and those that are about to leave the Armed Forces.

SPACES are a homeless and housing advice service who work with customers to source and secure accommodation all over the UK. SPACES are part of the national housing association Riverside, and also have exclusive referral rights to The Beacon, Catterick Garrison, Hardwick House, Middlesbrough and Mike Jackson House in Aldershot. These are supported housing projects specifically for single ex service personnel.

If any veterans are currently homeless, or threatened with homelessness, or require any further information please contact SPACES to make a referral or for further information. No local connection is required.

SPACES can be contacted:

- Email: spaces@riverside.org.uk
- Phone: 01748 833797 (Monday – Friday 9am-5pm)
- Referral form: via the Riverside website https://www.riverside.org.uk/care-and-support/veterans/spaces/

Support for international patients

The NHS provides healthcare for people who live in the United Kingdom.

People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport or have lived and paid National Insurance contributions and taxes in this country in the past.

There are clear regulations from the Department of Health which the Trust is required to follow in relation to Overseas Visitors and the charging of patients is based on the urgency of the treatment.

The Trusts Overseas Manager will have an understanding of the full scope of the charging regulations and can advise on patients' entitlement and sign post to any support available.

Details can be found on the trust Overseas Visitors SharePoint page:

https://nhscanl.sharepoint.com/sites/StrategyandBusinessDevelopment/SitePages/Overseas-Visitors.aspx.

Addiction support

The Well provides drug and alcohol addiction support in Barrow, Fleetwood, Lancaster, Kendal, Morecambe.

Services include day-hab, 12-step programme, mutual aid, peer mentoring, employment skills, sports and social activities.

Information is available at - https://www.thewellcommunities.co.uk/contact-us

Support for stroke patients

For a service overview, please see the diagram on the following page - Lancashire and South Cumbria Integrated Community Stroke Team Pathway

Therapy at Home (no care element)

A MDT would take place - which would be followed by discussion between the inpatient stroke team and the Integrated Community Stroke Team (ICST)

Following conversation, a referral would be made to the ICST - to determine service capacity in the community and establish when support could be provided.

After discharge, within 24 hours the patient will be assessed at home.

Reablement

Reablement support is provided via the established Discharge to Assess pathways.

Intermediate Care

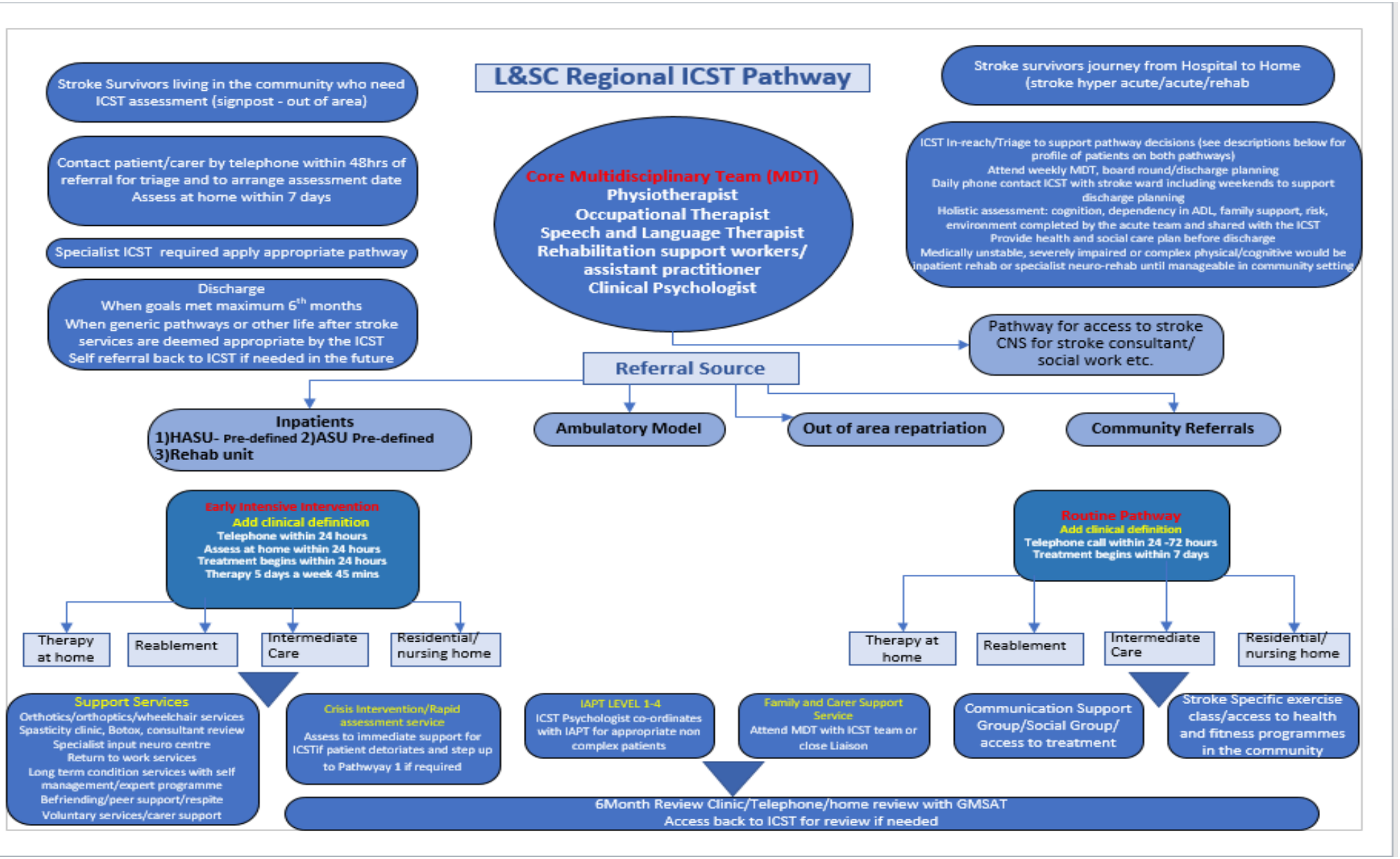
Dolphin Lee (Lancaster) is available for support - and accessed via the Discharge to Assess pathway.

Residential / Nursing Home

Residential or Nursing Home support is accessed via the established Discharge to Assess pathways.

Specialist stroke support can be provided to ensure a safe care plan is established - including moving and handling, skin care and quality of life support.

The specialist support is time limited - to ensure safe systems of support are established.


L&SC Regional ICST Pathway
Stroke Survivors living in the community who need ICST assessment (signpost - out of area)
Contact patient/carer by telephone within 48hrs of referral for triage and to arrange assessment date
Assess at home within 7 days
Specialist ICST required apply appropriate pathway
Discharge
When goals met maximum 6th months
When generic pathways or other life after stroke services are deemed appropriate by the ICST
Self referral back to ICST if needed in the future
Core Multidisciplinary Team (MDT)
Physiotherapist
Occupational Therapist
Speech and Language Therapist
Rehabilitation support workers/ assistant practitioner
Clinical Psychologist
Stroke survivors journey from Hospital to Home (stroke hyper acute/acute/rehab
ICST In-reach/Triage to support pathway decisions (see descriptions below for profile of patients on both pathways)
Attend weekly MDT, board round/discharge planning
Daily phone contact ICST with stroke ward including weekends to support discharge planning
Holistic assessment: cognition, dependency in ADL, family support, risk, environment completed by the acute team and shared with the ICST
Provide health and social care plan before discharge
Medically unstable, severely impaired or complex physical/cognitive would be inpatient rehab or specialist neuro-rehab until manageable in community setting
Pathway for access to stroke CNS for stroke consultant/ social work etc.
Referral Source
Inpatients
1)HASU- Pre-defined 2)ASU Pre-defined
3)Rehab unit
Ambulatory Model
Out of area repatriation
Community Referrals
Early Intensive Intervention
Add clinical definition
Telephone within 24 hours
Assess at home within 24 hours
Treatment begins within 24 hours
Therapy 5 days a week 45 mins
Routine Pathway
Add clinical definition
Telephone call within 24 -72 hours
Treatment begins within 7 days
Therapy at home
Reablement
Intermediate Care
Residential/ nursing home
Therapy at home
Reablement
Intermediate Care
Residential/ nursing home
Support Services
Orthotics/orthoptics/wheelchair services
Spasticity clinic, Botox, consultant review
Specialist input neuro centre
Return to work services
Long term condition services with self management/expert programme
Befriending/peer support/respite
Voluntary services/carer support
Crisis Intervention/Rapid assessment service
Assess to immediate support for ICSTif patient detoriates and step up to Pathwyay 1 if required
IAPT LEVEL 1-4
ICST Psychologist co-ordinates with IAPT for appropriate non complex patients
Family and Carer Support Service
Attend MDT with ICST team or close Liaison
Communication Support Group/Social Group/ access to treatment
Stroke Specific exercise class/access to health and fitness programmes in the community
6Month Review Clinic/Telephone/home review with GMSAT
Access back to ICST for review if needed

Fire and Rescue Service Support

The Fire and Rescue service can provide safety at home advice and a fire risk assessment support.

For Cumbria -
Phone: 0800 358 4777
Email: hart@cumbria.gov.uk

For North Lancashire-
Phone: 0800 169 1125
Email: contactcentre@lancsfirerescue.org.uk

For North Yorkshire
Phone: 01609 788545

'Duty to Refer' - if a patient may be homeless, at risk of becoming homeless or have any other associated housing issues

Acute, Mental Health inpatient, Accident and Emergency, Community and "Out of Hours" settings are required to provide early notification to Housing Options Teams using the "Duty to Refer" portal, when individuals are admitted or attend hospital settings, when identified as being homeless at risk of becoming homeless or have any other associated housing issues. This is in line with national policy (published 21 September 2018, updated 28th Sep 2018) by the Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government.
Please see link to full document: https://www.gov.uk/government/organisations/department-for-levelling-up-housing-and-communities

The details of any housing issues and a note that a referral has been made via the "Duty to Refer" portal should be noted on the patient's electronic record.

This early discharge planning is critical to ensuring a positive outcome for individuals and smooth discharge from hospital.

Where possible on admission to hospital or as soon as reasonably possible afterwards, as much information should be obtained relating to the patient's housing situation and the "Duty to Refer" referral form is required to be completed if housing issues are identified.

The duty to refer details for Cumbria, Lancashire (i.e., Lancaster) and North Yorkshire (i.e., Craven District) can be found in the table (see below).

For people that do not reside within Cumbria, North Lancashire or North Yorkshire (i.e., Bentham and Ingleton in Craven District) the district/borough where they are from will need to be informed using the "Duty to Refer" portal.

Once the **"Duty to Refer"** form has been completed electronically, the relevant Housing Options Team will make contact within 24 hours to discuss the patient's housing needs.

If the service user or patient is a refugee, asylum seeker or someone without recourse to public funds the Housing Options Team will contact the appropriate organisations to seek advice and assistance.

DUTY TO REFER PORTAL DETAILS AND CONTACT DETAILS

District	Office hours contact number	Link to Duty to Refer portal
Allerdale	01900 702 660 01900 871 080	dutytorefer@cumberland.gov.uk
Carlisle	01228 817 079 01228 817 368 (Out of Hours)	dutytorefer@cumberland.gov.uk
Copeland	01946 598 300	dutytorefer@cumberland.gov.uk
Craven	01756 700 600 01653 699 392 (Out of Hours)	dutytorefer@cravendc.gov.uk https://hpa2.org/referral/FormPage.aspx
Eden	01768 861 400	dutytorefer@westmorlandandfurness.gov.uk
Furness	01229 876 599 01229 833 311 (Out of Hours)	dutytorefer@westmorlandandfurness.gov.uk
Lancaster	01524 582 257 01524 67099 (Out of Hours)	dutytorefer@lancaster.gov.uk
South Lakes	01539 793199 0870 4286905 (Out of Hours)	dutytorefer@westmorlandandfurness.gov.uk

Note: Referrals should ideally be made via the **"Duty to Refer"** Portal (i.e. the Housing Assistance(Referral Portal) whenever possible to ensure that the Housing Options Team has all the information required.

Appendix 8: Admission Avoidance Support

The Transfer of Care Hub team will support admission avoidance, when transferring patients into short term care home beds whilst long term needs are assessed.

Patients will be stepped up from community settings / virtual wards to avoid unnecessary hospital admission.

This process applies to The Transfer of Care Hub staff, Urgent Community and Frailty Coordination Hub, Therapies, ICAT and Home First South Cumbria, Cumbria County Council and Lancashire County Council, ICB and General Practice.

This process is intended to reflect agreed operational practice and may therefore be amended from time to time with the agreement of all parties.

All with an invested interest in the patient have a statutory duty of care to adequately plan and transfer patients from community settings.

Patients expect that the continuation of their journey pending community services will be a good experience with the provision of high-quality care. Patients have the right to expect the transition between community and Transfer of care beds. beds to be smooth, timely and safe.

Inclusion Criteria

• Patients who are in the virtual ward, whose needs cannot be met but do not need a hospital admission

• End of life care

• Clinically stable patients who require Transfer of care beds., i.e., patient is at home and requires a 24-hour care placement as part of their longer-term plan and is medically stable.

Exclusion Criteria

• Any acute medical condition that would not routinely be managed by primary care services and Virtual Wards

• Any acute surgical or gynaecological condition

• Acute psychosis/Bipolar/Mania as the primary health issue

• Children under 18 years of age

• No COVID + patient, unless they have completed their 14-day isolation period and are symptom free

Identifying appropriate patients for transfer

Based on the criteria (1) the appropriate patient will be identified as follows:

• Will be on a case-by-case basis

• Identified by community teams, Rapid Response, GP

• The patient is at home and requires to be stepped up to prevent a crisis situation and they are clinically stable

• The patient meets the inclusion criteria

All members of the multidisciplinary team are able to identify potential patients to transfer to the Transfer of Care beds.

The Transfer of Care Hub will have clinical oversight while patients are residing in the Step – up beds whilst long term needs are assessed.

Estimated Date of Discharge

Patients who are Transfer of Care beds to 24-hour care, will consider for eligibility for a Continuing Healthcare process if they are at Nursing Level and above i.e., EMI. For those patients at residential level a referral will be made with consent / agreement to Adult Social Care.

This mandated process will take place within 28 days of admission.

Communication with the patient regarding the transfer to Transfer of Care Beds

Once an appropriate patient is identified the possible transfer of care must be discussed with the patient and if appropriate their relatives/carers and consent gained.

The function of Transfer of care beds. beds must be explained. All conversations must be fully documented in the patient's case notes on EMIS.

Complying with the trusts open and honest policy the need to progress the patient journey must to be explained and the benefits to the patient moving to a Step –up bed.

Completion of assessment prior to acceptance for Transfer of Care Beds

To ensure compliance with the Care Quality Commission (CQC) the Transfer of Care beds will require a handover to ensure they are able to meet the needs of the patient. This will need to be completed by the community team that are currently involved in the patient's care.

Community team will complete capacity and Best Interest Assessment if appropriate for Transfer of Care beds.

Transfer Date and Time to the Transfer of Care Beds

The patient and/or if appropriate their relatives will be notified when their admission to 24-hour care will take place.

Check In / Check Out Details

Patient's that have been assessed on a Friday can be transferred during the weekend if agreed with relevant 24-hour care setting.

All patients will be tracked on a patient tracker, managed internally by the Transfer of Care Hub team.

This will allow for a record of all patients who are currently receiving care, and allow for the teams to understand current bed availability.

In addition, the tracker will be able to log how many patients have been through the service.

The Transfer of Care Hub administrative colleagues will, where appropriate, make the necessary referrals to Cumbria / Lancashire County Council's Adult Social Care teams in a timely manner as appropriate.

Transfer Documentation

• The Transfer of Care Hub need to ensure funding letter has been sent to relevant care home

• Patient is placed on patient tracker

• The community team need to ensure DNACPR is sent with patient

• The community team/family need to inform 24-hour care setting of any Outpatients Appointments

• GP to be informed of patients of admission to Step –Up bed

Medications and other supplies

The community team will need to ensure that all medications are transferred with the patient to the relevant care home.

The community team need to ensure that both patients current GP and if appropriate Temp GP are involved in move. In the instance of a patient stepping up from the community the community team will notify the GP.

A 7-day supply of wound care dressings will be sent on transfer if the patient has on-going wound care needs which require treatment.

Repeat Prescriptions

The relevant 24-hour care setting will ensure the patients repeat prescription is re-ordered in preparation for the end of their current prescription to ensure that the patient has sufficient supplies on discharge from them.

Transportation
If the patient is unable to arrange their own transport, then the Transfer of Care Hub will arrange transport to collect the patient from the community.

Northwest Ambulance service will manage the transport service for patient who;

• Are being transferred to a Transfer of care bed

• Each care home will identify a member of staff to liaise with NWAS and arrange transport when needed.

For all transport booking please 0800 0323 240

When making a booking for a patient, as well as their name and address you will always need the following information available: NHS number, G.P practice, details of travel and mobility status.

Medical Cover
Medical cover will be the usual GP who supports the relevant care home.

In the event of a patient being stepped up in the community, and where suitable to remain on the virtual ward, this will be communicated with the GP.

Acute Clinical Deterioration
In the event of a patient deterioration and in the absence of a management plan indicating not for any escalation of management the medical provider will undertake a review.

If an admission is required, then the medical provider will arrange admission and transport via Northwest Ambulance Service.

In a life-threatening situation the care home must ring 999 for a paramedic.

The care homes must notify the Transfer of Care Hub of any patient who is being stepped back up to UHMB.

FGH – 01229 403969

RLI - 01524 512332

For all patients the bed will be held until a decision is made dependent of the condition of the patient.

Discharge from the Step – up beds
If appropriate, and patient is to return home, appropriate discharge pathway will be decided and agreed with patient, family and relevant adult social care and community teams.

COVID-19
Pre-admission testing requirements

• No one will be Stepped Up into a registered care home setting with a COVID-19 test result outstanding, or without having been tested within the 48 hours preceding their discharge

• All patients being stepped up from community will require

• LTF negative test, if patient has had a COVID positive status within 90 days

• PCR negative test if a patient has not had COVID positive status within 90 days

Governance
Any incident must be logged via the care homes incident reporting system.

The care home must escalate the incident to the discharge team in UHMB.

Progress meetings
The Transfer of Care Hub team will monitor all patients in the Step –Up beds.

Appendix 9: Westmorland and Furness Locality Support Part 1

Support for Carers

Furness Carers provide free and confidential information and support to carers, of all ages, on all issues related to their caring role.

Colleagues from the service are based in the Furness General Hospital Transfer of Care Hub several days per week.

To contact call: 01229 822822 or email: admin@furnesscarers.co.uk

For further information please visit -
www.furnesscarers.co.uk

Equipment Provision

Items of equipment can be ordered via the Cumbria County Council Elms system - Case Managers, OTs and District Nurses in the FGH and RLI teams have access to the system. OT's have access to immediate issue ADL equipment at Furness General Hospital.

Housing Support

Furness

For Homeless or potentially homelessness clients contact should be made through dutytorefer@westmorlandandfurness.gov.uk.this would include if someone potentially cannot return to their home for a number of reasons i.e., home is not suitable due to disability, repairs needed by landlord etc. the homeless team try to prevent homelessness at the earliest opportunity so linking in through Duty to Refer when a patient is admitted can greatly help the situation.

For Barrow Borough Council Housing Tenants again the earliest opportunity when a patient is admitted contact should be made through Safe and Strong Communities Team. The Team Leader for the Team is Debbie Cubiss – dcubiss@westmorlandandfurness.gov.uk or Manager is Caroline Kendall – ckendall@westmorlandandfurness.gov.uk

Team colleagues attend all the MDT Meetings for frailty, mental health where cases are referred in If a Private Sector Housing case where deep clean maybe needed under filthy and verminous our Public Protection colleagues would be the point of contact, please refer in on environment@westmorlandandfurness.gov.uk

Structures of organization-
Council Tenants – Safe and Strong Communities Team – Caroline Kendall Manager – ckendall@westmorlandandfurness.gov.uk
This can also be completed by filling in the online form on trust intranet page
Homeless Team – Amanda Brierley – Manager contact is through dutytorefer@westmorlandandfurness.gov.uk.
Private Sector Tenants/Owner Occupiers either be through our Homeless Team or Public Protection as above.

Assistance with Choice Based Lettings CBL Forms – Jackie Rimmer is Team Leader jrimeer@westmorlandandfurness.gov.uk

Mental Health support (LSCFT)

The Community Mental Health Team – Older Adult – Furness

Older Adults Furness cover: Barrow, Dalton, Ulverston up to Newby Bridge (this side of Newby Bridge) Hawkshead, west side of Coniston and Millom up to Bootle.

The Community Mental Health Team for Older Adults in Furness comprises of 4 smaller teams:-

- **The Early Memory Team –** This team provides an assessment process for people of any age with a suspected dementia. It consists of 4 Mental Health nurses who provide a comprehensive assessment from referral through to diagnosis and treatment if required and has a 15 day access time limit from acceptance of the referral to the initial assessment. There is also access to an Occupational Therapist, Clinical psychologist, Support Workers and a Psychiatrist.
  All initial assessments are completed by a Mental Health Nurse and then discussed with a psychiatrist. Diagnosis can be delivered by the nurse or the psychiatrist depending on the patient's preference.
  Treatment will be initiated and titrated initially within the team and post diagnostic sessions are offered as required.
  Transfer to another team within the CMHT may be considered depending on treatment and complexity or discharge will be considered if no treatment is offered and care needs have been introduced or exhausted.
- **The Complex Team –** This team provides an assessment/treatment process for people over the age of 65 years with a functional illness or complex on-going needs arising from a diagnosis of dementia.
  The team has only recently started accepting people with a functional illness therefore this is function of the team is still in its infancy.
  The team consists of 3 Mental Health nurse who provide care co-ordination to patients. They also has access to an Occupational Therapist, Clinical Psychologist, Support workers and a Psychiatrist.
- **The Cognitive Enhancer Team –** This team reviews the efficacy of medications prescribed for people with a diagnosis of Dementia. (They are not used to treat Vascular Dementia). The reviews are completed on a yearly basis.
  The team consists of 2 Assistant Practitioners who provide care co-ordination. They also have access to an Occupational Therapist, Clinical Psychologist, Support Workers and a Psychiatrist.
- **Hospital Liaison/CHESS Team –** The hospital liaison part of this team provides a support and advice service to Furness General Hospital for patients of any age with a dementia. If a request for an assessment for a diagnosis of dementia is made, this will be deferred for a 3 month period following admission to ensure an incorrect diagnosis is not give. Referral can be made directly to the team. There is dedicated Medic time for hospital liaison, (4 hours per week).

The CHESS part of the team provide a support and advice service to nursing and residential homes. They hold monthly clinics in the homes where referrals are generated from.
The team consists of 2 Mental Health nurse and a dedicated support worker. They also have access to a psychiatrist as required.

The CMHT-OA-Furness is based at Dane Garth and operates during the hours of 9am – 5pm, Monday to Friday.

To make referrals-

Furness Team:
Email: MLL-Furness@lscft.nhs.uk
Tel No: 01229 404365
(The Team don't routinely accept telephone referrals, though would respond to urgent requests etc. via their team number)

Team Lead

OA CMHT Furness: Claire Kaye Tel: 01229 404365 (Monday-Friday 9am-5pm)

Appendix 10: Westmorland and Furness Locality Support Part 2

Support for Carers

Carer Support South Lakes identifies the needs of unpaid Carers of any age and provides quality services, support and advocacy to promote their health and wellbeing

To make referrals - please complete a referral form and email to-

admin@carersupportsouthlakes.org.uk

For further information please call 01539 815970 or visit -

www.carersupportsouthlakes.org.uk

Equipment provision

Items of equipment can be ordered via the Cumbria County Council Elms system - Case Managers, OTs and District Nurses in the FGH and RLI teams have access to the system. OT's have access to immediate issue ADL equipment at Westmorland General Hospital.

Housing support

South Lakeland District Council

Contact details are as follows:

1. Housing Options – email homelessness@southlakeland.gov.uk, Tel 01539 793 199, Duty to Refer form is available on the Council's web-site

2. Housing Standards, Disabled Facility Grants and Handyperson service – housingstandards@westmorlandandfurness.gov.uk, Tel – 0300 373 3300 more information and the type of jobs that this can support with are on the web-site along with a form.

3. Environmental Protection publicprotection@southlakeland.gov.uk Tel 01539 733 333.

4. South Lakes Housing (if they are the landlord) 0300 303 8540 (24 hour) customerservices@southlakeshousing.co.uk. SLH have an Independent Living Service which can do smaller disabled adaptations on their homes that may help facilitate a discharge. NB this is a housing association and not part of the Council but they are the main provider of social housing in South Lakeland with properties throughout the District.

Mental Health support (LSCFT)

The Community Mental Health Team – Older Adult – South Lakeland

Older Adults South Lakes cover: Newby Bridge from the roundabout East side and the east of Lake Windermere. We go as far north as Grasmere, then Ambleside. East to Dent including Sedbergh, Kirkby Lonsdale, Burton in Kendal, Milnthorpe, Holme and Arnside. Grange-over Sands, Flookburgh, Cartmel.

CHESS (CHL) team will support with discharge to care home following a settling in period. We do get regular and immediate referrals from the care home for someone who has been discharged from hospital and has immediate agitation but this is often due to the placement not being appropriate/ delirium.
All referrals require a physical health screen prior to being seen by the mental health team to rule out delirium.
One of the big elements of the CHESS team is Occupational Therapy to look at meaningful occupation for people with dementia in care homes, particularly to prevent urgent need and the overuse of medication.

The Memory Team assess and diagnose people who are referred in for assessment, usually by a GP following a memory blood screen. When people are discharged from hospital the team sometimes receive an immediate referral for memory assessment but it is important to allow people to have a period of settling in before this is undertaken. The team do not recommend memory assessment for people in hospital as it is not their usual home and it would not give an accurate baseline of memory or ability.
The memory team have access to OT for assessment. The team will also signpost to other organisations for support post diagnosis, such as Dignity in Dementia, South Lakes Carers, the Alzheimer's Society, Age UK South Lakeland, Adult Social Care etc. The Memory Team also offer medication to slow down the progression of dementia, which is monitored initially by the titration team. Memory assessments do not have a lower age limit.

The Complex team offer mental health assessment and support for those over the age of 65 who have a functional mental health condition. They will also see people with complex memory issues post diagnosis and with other health conditions such as Parkinson's disease when memory is affected or a person has hallucinations.

The team get referrals from hospital liaison team to all of our functions and liaise with them as necessary.

The team do lots of co working with other agencies such as ACS, CHC GPs voluntary organisations. The majority of work involves liaison with families and carers.

The team can offer advice and information to other professionals about patients or who would be most appropriate to refer people on to. We can offer education sessions also.

To make referrals-

South Lakeland Team:

Tel No: 01530 462597 / 462598
Email: lcn-tr.mllsouthlakes@nhs.net

Appendix 11: North Lancashire Locality Support

Support for Carers

Carers Lancashire provides a range of support including - carers' assessments; carers' personal budgets and support plans to those eligible; help planning for an emergency if you cannot carry out your caring duties; carers forums/support groups; sitting in service; information and advice.

For further information please call 0345 688 7113 or visit -

https://www.lancashire.gov.uk/health-and-social-care/adult-social-care/caring-for-someone/#:~:text=If%20you%20think%20you%20are,carers'%20assessments

Equipment provision

Items of equipment can be ordered via the Lancashire County Council TCES system - Case Managers in the RLI team have access to the system. Larger items, i.e. hoists and hospital beds, can be ordered through TCES/MEDIQUIP by OT's.
OT's can issue ADL equipment via prescription (retail model).

Age UK Lancashire Hospital Aftercare Service (support for Pathways 0 and 1)

The Age UK Lancashire Hospital Aftercare Service can provide a Take Home and Settle Service for patients who may need some short-term support after a hospital stay.

Information about the service is available at - https://www.ageuk.org.uk/lancashire/our-services/hospital-after-care-service/

For Hospital Aftercare Service support for **pathway 0 patients**, please contact - 01524 387832 or email - hasnorth@ageuklancs.org.uk

The service is available Monday to Friday: 9am - 7pm, including bank holidays. Saturdays: 9am - 5pm

Hospital Aftercare Service is delivered across the Lancaster District and surrounding areas, and Fylde & Wyre.

Referrals for **pathway 1 patients** are facilitated by ICAT colleagues.

Housing support

Lancaster City Council

For patients being discharged back home, where repairs, adaptations or assistance with cleaning homes is required. Referrals (form below) can be sent direct to the Home Improvement Agency dedicated mailbox - hiaenquiries@lancaster.gov.uk .

The Homeless team - general number for homelessness - 01524 582257.

For enquiries relating to Choice Based Letting the contact number is 01524 582005.

Hospital Discharge Referral to Lancaster City Council Home

Improvement Agency (HIA) for assistance with Repairs/Adaptations

<table>
<tr><td colspan="4">Patients Details</td></tr>
<tr><td colspan="4">Name/Address:

Date of Birth:

Telephone/email:

Alternative Contact Info:

Ethnicity:</td></tr>
<tr><td colspan="4">Tenure: (Tick where appropriate)</td></tr>
<tr><td>O/O</td><td>Private Rent</td><td>H/A</td><td>Council</td></tr>
<tr><td colspan="4">Has Landlord permission been obtained? Yes/No

Landlord name/address if known: Telephone/email</td></tr>
<tr><td colspan="4">What is the reason for the referral?</td></tr>
<tr><td colspan="4">Any other relevant information:</td></tr>
</table>

Minor Adaptations required to patients' home		
Item	Quantity	Details
External Rail		
Bannister Rail		
Step		
Non-Standard		
Has a prescription been issued? Please provide full details		
Does the patient or their property pose any risk to HIA staff?		
What is the planned discharge date?		
Name of Referrer		
Organisation		
Contact Information		
Date completed		

Mental Health support (LSCFT)

OA Lancaster and Morecambe and RITT cover: Carnforth, Morecambe and Lancaster, currently also cover up to and including Garstang but in the near future those patients under Garstang will come under Fylde and Wyre.

RITT

The RITT Team was established in 2014. There are 3 primary functions of RITT: Single Point of Access (SPoA), Home Treatment Team (HTT) and Care Home Liaison (CHL).

SPoA complete all the initial assessments and offer a compassionate and timely response to referrals. Routine referrals are triaged within 10 working days and urgent referrals are triaged within 24 hours. We recognise that our patients and carers know their illness, therefore we accept self-referrals from our patients when they are in crisis. Whilst we have a target age of 65+, we are also an ageless service and assess people based on their symptoms and presentation. SPoA work Monday – Friday 9am to 5pm daily.

The HTT function is an Older Adult Crisis team for both organic and functional illnesses.

It is a multi-disciplinary team of healthcare professionals offering a holistic and intensive period of care. The team support patients to remain in their home environment and to avoid, where

possible, hospital admissions. The team formulate and deliver person- centred care to ensure the patient's journey to recovery is seamless and timely.

HTT service works 7 days a week 8am to 8pm. The team is made up of Nurses, Occupational Therapists, Support Workers, Psychology and Students.

The CHL service works Mon-Friday 9am-5pm. The Team support patients with a suspected or diagnosed dementia who reside in a care home. They aim to use non-pharmacological approaches to support patients and care home staff in managing Behavioural and Psychological Symptoms of Dementia.

In summary; RITT work to treat people at home, prevent hospital admissions and work to minimise risks whilst remaining at home. They are the gatekeepers for hospital beds when admission in unavoidable, facilitate early discharge from hospital and support care homes to maintain placements using intense, short-term interventions tailored to the needs of the person and their Carers.

Working with the RLI

In working hours, any RITT patients in the RLI would be seen by RITT, unless by prior arrangement with Mental Health Liaison Team. Any patients known to RITT or CHL, moving into a care home would be seen, as required, when they are discharged to a care home (within our locality).

Lancaster and Morecambe Memory Assessment Service : Carnforth, Morecambe and Lancaster area; Garstang patients already come under Fylde.

Lancaster and Morecambe Memory Assessment Service (MAS)

This specialist service is primarily clinic based and provides a quality assessment process and diagnostic outcome for people with suspected dementia. Lancaster and Morecambe Memory Assessment Service (MAS) serves the populations in the following districts within The Bay Locality: Carnforth, Morecambe and Lancaster. Home visits are accommodated for as required. Patients living in the Garstang area are served by Fylde Coast MAS

All referrals to Lancaster and Morecambe MAS are processed via the Single Point of Access (SPoA) for Older Adult Mental Health Services in the same area. MAS is a non-urgent service pathway, but aims to establish initial contact and commence assessment within a 6 week time frame for a timely diagnosis.

The service uses a consultation model to formulate the patient diagnosis and plan future care and treatment possibilities. The diagnosis is shared by the assessing clinician or medic and treatment options are explored with the patient. A post diagnostic session is offered to all patients and caregivers. This is where the diagnosis can be discussed and future opportunities for support are considered. Patients are discharged from the service following their diagnosis unless prescribed medication, though this aspect of the service is currently under review.

Lancaster and Morecambe MAS is comprised of a small multi-disciplinary team consisting of 4 Nurses, 1 Occupational Therapist, 2 Medics, 1 Psychologist, 3 Admin and 1 Team Manager. A Dementia Advisor from the Alzheimer's Society also works closely alongside the team for continued information and support for patients after diagnosis and discharge.

The service has a close affiliation with other older adult mental health services; Older Adult CMHT for complex care and the Rapid Intervention and Treatment Team (RITT) for urgent response and Care Home Liaison. Links are also in the process of being established to provide specialist advice and support to Care Co-ordinators in Primary Care, providing a more collaborative and integrated approach to care.

To make referrals-

Older Adults in Lancaster and Morecambe:
Via Single Point of Access (SPOA): **Monday-Friday 9am-5pm**

Tel No: 01524 550630
Email: Lcn-tr.oamhreferralsdevitrehs@nhs.net

Team Leads:

RITT: Adam Hancock Tel: 01524 550154 (**RITT is a 7 day service and operates 8am-8pm)**

OA CMHT: Karen Sagar Tel: 01524 550133 (Monday-Friday 9am-5pm)

MAS L&M: 01524 550143 (Monday-Friday 9am-5pm)

To refer Garstang patients please use following process and form -

ROUTINE REFERRAL FORM FOR LSCFT FYLDE COAST ADULT & OLDER ADULT MENTAL HEALTH SERVICES

Please complete and send to the appropriate Single Point of Access (SPoA)
Referrals are screened daily and triaged within one working day

Adult Mental Health Wyre and Fylde Single Point of Access (SPoA): Fylde&WyreSPA@lscft.nhs.uk
(NB Blackpool Teaching Hospitals provide the SPoA for Blackpool Adult Mental Health referrals and are accessed via Tel 01253 951225 or BFWH.singlepoint.access@nhs.net)

Older Adult Mental Health, Fylde Coast Single Point of Access: BFWSPoAOA@lancashirecare.nhs.uk

URGENT REFERRALS for immediate attention must be made by phone call discussion with the SPoA duty worker and be followed up with a written referral sent via email.
Adult Mental Health Wyre and Fylde SPoA (9-5) Tel 01253 955944
Older Adult Mental Health Fylde Coast SPoA (9-5) Tel 01253 957581
Out of hours Fylde Coast SPoA (5pm-8am) Adult Home Treatment Team Tel: 01253956278

Surname	Forename	DOB		Age	
Title	NHS No	Gender	Male Female Other		
Address Postcode E mail Tel: home mobile	Registered GP Surgery	Marital Status	Single Married Divorced Widowed Other		
		Ethnic Origin			

This section MUST be completed OR REFERRAL MAY NOT BE ACCEPTED

How does the person prefer to be contacted? Can a message be left on an answerphone? Please highlight any special needs or considerations e.g. interpreter	**Please underline or circle** Military Veteran Perinatal/Postnatal Has the patient given consent for their care to be discussed with appropriate agencies. **Are there any consent restrictions** please name who CANNOT be contacted

Risk to self or others *(including risk from associates of client)*

	current	historic	Please give details (continue below if necessary) inc risk to staff
Self harm			
Verbal abuse			
Threatening behaviour			
Physical violence			
Self neglect			
Substance misuse			Current level of risk Please underline or circle NIL LOW MEDIUM HIGH
Risk to Children			

Risk to Self and Others cont'd:
What risk do they present? What destabilises/triggers the risk? What maintains the risk? What keeps them or others safe? Is there any forensic history known?

Please give details of the <u>presenting problems/ reason for referral</u>: Symptoms, frequency, level of distress, primary diagnosis and treatments tried, who else is currently involved , physical health conditions impacting, safeguarding, impact on functioning - personal, occupational any social needs, interventions you think may be helpful

Previous mental health history; What service have they had before? Primary care mental health service assessment? details of any other services previously involved particularly safeguarding.

Current Medication: please detail date commenced and dosage

PLEASE ENSURE THE REFERRAL FORM IS COMPLETED CLEARLY AND FULLY SO THAT WE DO NOT HAVE TO RETURN IT AND DELAY ASSESSMENT. PLEASE SEND ANY ADDITIONAL INFORMATION YOU FEEL IS RELEVANT.

Name & occupation of Referrer:

Date:

Signature:

Contact number and email:

Appendix 12: North Yorkshire Locality Support
Link to printable version: Transfer of Care - North Yorkshire Locality Support.docx

Support for Carers

Carers Resource provides support for carers in North Yorkshire.

For further information - please call 01756 700888 or visit -

https://www.carersresource.org/what-we-do/for-carers/

Equipment provision

Small items of equipment can be ordered via the North Yorkshire County Council TCES and Medequip systems - four Case Managers in the RLI team have access to the systems.

Home from Hospital Service

Home From Hospital in North Yorkshire is a free service for people aged 18 and over who are being discharged home and need extra support.

The service supports people who:

- Are aged 18 or over
- Live in North Yorkshire
- Have been at A&E, had a day procedure or a hospital stay
- May also have NYCC Reablement support

The Home from Hospital can ease a return home, assisting to re-build confidence and independence and preventing hospital re-admission.

Short term support is available, dependent on an individual's needs and may include:

- Support for family/friends who are caring for a person recently discharged
- Liaising with Health and Social Care professionals
- Help to access appropriate services and organise ongoing support
- Essential food provision
- Prescription collection and medication checks
- Telephone support and keeping in touch
- Light household tasks

The service is unable to assist with:

- Personal care (washing, dressing, toileting, TED stockings)
- Giving/prompting medicines
- Providing medical care

For further information about the service - please visit -

https://www.carersresource.org/post-hospital-services/north-yorkshire/

Or call - 0300 365 4600

To make referrals to the service, please complete the form on the following page -

https://civicrm.carersresource.org/hfh_ny_referral

Accessing Support at Castleberg Community Hospital - Settle, North Yorkshire

Hold initial conversation with Community AP - can be contacted on 07920 458224

If agreement patient could be supported at Castleberg - complete referral form and email to - **Airedale Digital Care Hub - digital.carehub@nhs.net (01535 292797)**

Castleberg Hospital will confirm acceptance and place on waiting list

Castleberg Hospital will liaise with ward and Complex Case Manager regarding position of patient on waiting list

Agreement of discharge date with patient and Castleberg Hospital

Transport to be booked (for morning) - patient must arrive at Castleberg prior to lunchtime to allow for AP to clerk patient into hospital

Full discharge summary needed - together with 7 days TTO's

For further details please see the Bed Based Intermediate Care Operational Guideline for Castleberg Hospital.

Mental Health support - Bradford District Care NHS Foundation Trust (BDCFT)

For urgent referrals please contact - First Response - 0800 952 1181

For non-urgent referrals please email - firstresponseadmin@bdct.nhs.uk

Or call - Single Point of Access - 01274 221189

Appendix 13: 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 due to the nature of the document we will need to monitor continuously	Relevant Executive Director, Discharge Lead	Morecambe Bay Discharge Steering Group
2. Organizational 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 due to the nature of the document we will need to monitor continuously	Relevant Executive Director, Discharge Lead	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 due to the nature of the document we will need to monitor continuously	Relevant Executive Director, Discharge Lead	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 due to the nature of the document we will need to monitor continuously	Relevant Executive Director, Discharge Lead	Morecambe Bay Discharge Steering Group

Appendix 14: 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 15: 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	22/3/2023	
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 socioeconomic background, people with diverse gender identities, human rights)	Positive	Support for carers and veterans will be championed by 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.