Adult Services and Wellbeing
Calderdale Metropolitan Borough Council

# Standard Operating Procedure (SOP): Hospital Discharge Pathway 2.

# Contents

# Procedure Version Control

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| **Procedure Name** | **Standard Operating Procedure: Hospital Discharge Pathway 2** | | |
| **Document Description** | This Standard Operating Procedure sets out the Hospital Discharge Pathway 2's aims, objectives, underlying principles together with consistent ways of working. | | |
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# Hospital Discharge Overview

To provide timely and safe discharge from Intermediate bed base care setting for those who need social care services to facilitate their discharge.

# Hospital Discharge Main Aims

**Enhance Quality of Life:** Improve quality of life by promoting independence and choice.

**Ensure Safety and Well-being:** Ensure adults with care and support needs have those needs identified and are supported to be safely discharged from Intermediate care.

**Provide Personalised Care:** Deliver care and support that is tailored to the specific needs and preferences of people whilst focusing on a person's strengths and local and community support network.

**Support Carers:** Recognise and support the vital role of unpaid carers in providing care. To work in partnership with carers in promoting people' independence.

# Intermediate Care Discharge Objectives

**Prevention and Early Intervention:** Focus on good quality care and choice and control of the person receiving care. Ensure timely reviews to allow support to be right sized after recuperation.

**Integration of Services:** Promote integration and coordination of health and social care services to provide seamless support to tailored personal services.

**Assessment and Eligibility:** Conduct thorough strength-based assessments to determine the persons needs and eligibility.

**Care Planning:** Develop personalised care plans that outline the support and services required to improve wellbeing, functionality, recuperation, and independence.

**Access to Services**: Ensure that people have timely access to a range of care services tailored to their personal circumstances.

**Empowerment and Choice:** Empower people to make informed choices about their care and support.

**Workforce Development:** Invest in the recruitment, training, and retention of a skilled and compassionate social care workforce.

**Community Involvement:** Encourage community engagement and the development of support networks to enhance social inclusion.

**Quality Assurance:** Monitor and evaluate the quality of care to ensure it meets high standards and continuously improves.

**Cost-Effectiveness:** Ensure resources are used efficiently to provide high-quality care while managing public funds responsibly.

## Intermediate care Discharge Outcomes

- Ensure a good discharge experience for the people of Calderdale.
- To provide good quality care for those leaving intermediate care settings.

## Values and Principles of the Hospital Discharge Service

- The Service aims to provide high quality services, which are economic, efficient, and effective.
- To ensure equity of access and equality of opportunity.
- To provide protection under the safeguarding process to those who require a service when and where needed.
- To work effectively in partnership with other services, agencies, and communities.
- To be open, transparent, and accountable to people who have an interest in intermediate care services.
- To be a learning organisation/service that seeks continuously to improve through innovation and flexibility.

## Eligibility Criteria

People must be residents of Calderdale in accordance with ordinary residence. Identified needs means the person is not safe at home between care calls. The person must have extensive nighttime needs that would not be managed by maximum of 2 visits per night. The person must have identified goals to improve independence/reduce dependency on services and must be able to agree/participate in the service offered.

# Service Area Process and Procedures

## Initial Contact

All referrals are received by email.

## Assessment and Eligibility Process

All assessments are conducted within the service setting and the person/carer/family/friends are involved. The assessment identifies the level of need and determines the most appropriate care provision.

## Financial Assessment

At the point of a determination of ongoing care being needed a discussion about the potential cost of care services and the likelihood of the person having to pay a charge will be initiated. This conversation helps manage expectations and ensures people are aware of any potential financial impact. The assessor is responsible for providing the financial information pack to the person. The pack contains crucial information about potential care costs and can be accessed online via the calculator: Care Charge Calculator. During the assessment signed confirmation from the person acknowledging receipt of the financial information pack will be obtained using the form designed for this purpose.

## Care and Support Plan

A care and support plan are devised with the person/carer/family/friend after assessment.

## Care and Support Services

The appropriate services are determined at the point of assessment in collaboration with the person/carer/family/friend. If there are disputes specifically around 24-hour care and the person does not have capacity or the carer/family/friend does not have lasting power of attorney, then an independent Mental Capacity Advocate is referred for..

## Review of Care and Support Plan

A review of the support plan is conducted within 6 weeks and ongoing services are determined.

## Case Note Recording

All case notes are inputted into Calderdale's data system and health system.

## Waiting Safe and Well for Assessment Process

Everyone who is referred is within the service setting and receiving care and support. Therapy will continue until discharge to prevent deconditioning.

## Information Sharing

During the assessment process the person will be asked for consent to share information. The person will also be asked if there is anyone/service they do not wish their information to be shared with. In general, the information is shared with health, service provider, carer/family/friend. All staff have completed training on GDPR and sharing information.

## Risk Assessment and Safety Planning

A full risk assessment is conducted in the service setting however home visits can be conducted to establish accessabiity. At the point of review a risk assessment is conducted if necessary.

## Roles and Responsibilities

### Team Manager:

Overall responsibility of the team performance and quality. To approve pathways and budgets. To carry out or oversee HR processes and supervisions of staff, including workload management. To Liaise with CHFT staff where necessary to improve flow. To ensure Intermediate care services are fully utilised and flow is maintained. To focus on length of stay and assist CHFT in reduction of this. Oversee all safeguarding processes.

### Team Leader:

Overall responsibility of the supervision and workload management of the below staff. Responsible to ensure timely allocation and that people receive timely assessments. To approve budgets on the system or seek budget approval from management for those packages above £500. To approve pathways. To work with CHFT to continually improve the service and the flow out of hospital and Intermediate Care service. To ensure the reviews from ILO's are conducted in a timely manner. To provide matrix professional support to the ILO'S in both UCR and Reablement. To screen all work including safeguarding concerns.

### Service Co-Ordinators & Social Workers:

To provided strength-based assessments for those people in hospital and Intermediate Care (where necessary) and facilitate safe and timely discharges to their destination. To carry out mental capacity act assessments and best interest decisions when deemed appropriate. To carry out any safeguarding enquiries as appropriate.

### Provision Planner:

To source placements for the HSWT and to negotiate prices of placements with providers. To carry out referrals for packages of care from ILO's, Service Coordinators, Discharge Coordinators, and Social Workers ensuring evidence of financial conversions have occurred.

# When to raise a Safeguarding Concern

***Overview**:* Stage 1 involves the identification and reporting of safeguarding concerns before the Safeguarding Adults Practitioners engage with the person at risk or experiencing abuse or neglect.

Practitioners will be mindful of S42 of the Care Act 2014, identifying where there may be a cause for concern that someone with possible care and support needs, in their area may be at risk of or experiencing harm or neglect and unable to protect themselves. This includes but is not limited to; physical abuse, emotional and psychological abuse, financial abuse, sexual abuse, coercive controlling behavior, and self-neglect.

Practitioners will have a responsibility for accurately identifying concerns, the source, type of harm, impact of harm/potential harm and urgency of the concern. Practitioners should consider and follow the Calderdale Threshold Guidance for Safeguarding Adults at Risk prior to raising a concern.

If practitioners are actively involved with a person whereby concern or information is shared, whether factually supported or not, they will make enquiries to ascertain that the person is safe and well and ascertain what action needs to be taken and what legal framework this may be under. This includes considering if this requires raising as a statutory safeguarding concern. This should be led by the person with Making Safeguarding Personal (MSP) underpinning the approach. Capacity to consent to safeguarding concerns should be considered at the point a potential safeguarding concern is identified, ensuring that the person is supported to engage with and understand what this means. In the event a person is deemed to lack capacity to consent, consideration should be given for involving a relevant representative and/or referring for an advocate. Only in circumstances where there is an immediate risk to the person and/or to the safety of another person should consent not be sought prior to raising a safeguarding concern.

Practitioners will formally report a safeguarding concern by completing the standard Calderdale Safeguarding Raising a Concern form and submitting this electronically to Gateway to Care via email. If any social care practitioner (with access to CIS) identifies the concern they will be responsible for completing respective safeguarding stage one screens on CIS.

Practitioners retain a responsibility to promoting the welfare and safeguarding children and young people (s11, Children's Act 2004) also. If information comes to the attention of a worker that a child or young person may be experiencing or at risk of harm or neglect, they will share this information with Children's services within a timely manner. This may be by contacting Multi Agency Screening Team (MAST) or sharing information with an allocated children's worker or team.

## How to Raise a Safeguarding Concern

### During Office Hours

- **General Public and Professionals**: Concerns can be reported by anyone in accordance with the guidance and consideration to The Threshold Guidance for Adults at Risk in Calderdale. Reports can be made via:
    - **Safeguarding Concern Form**: Complete and submit the form to gatewaytocare@calderdale.gov.uk .
    - **Telephone**: Call Gateway to Care at 01422 393000.

- **Safeguarding Adult Team Contact Details:**
    - **Telephone (Duty):** 01422 393375
    - **Email:** safeguarding.adults@calderdale.gov.uk

- **Specific Agencies**:
    - **Police, Yorkshire Ambulance Service**: These agencies may use their own forms to notify **safeguarding concerns.** These forms are accepted as valid notifications or referrals.
    - **Calderdale & Huddersfield Foundation Trust**: Will submit concerns where the abuse or neglect occurred within a hospital setting to the Hospital Discharge Team. It is likely that the Hospital Discharge Team will give cause to the Hospital to make the safeguarding enquiries, with the Hospital Discharge Team acting as co-ordinators.

### Out of Office Hours:

- **Emergency Duty Team (EDT)**: For concerns raised outside standard office hours (5:00 PM to 8:45 AM Monday to Thursday and 4:30 PM to 8:45 AM Friday to Monday), contact the EDT at 01422 288000. The EDT will assess the concern, take necessary immediate actions to address immediate and imminent risks (that cannot safely wait until the next working day), and notify Gateway to Care on the next working day.

## Notification, initial screening and processing

### Gateway to Care Responsibilities:

- **Electronic Concerns. Inputting into CIS**: Upon receipt, Gateway to Care will promptly check whether or not the person has a CIS record. Gateway to Care will create a record if there isn't one. Gateway to Care will then forward the electronic form on email to the Safeguarding Adults Team mailbox or (for people with a primary support reason around mental health) go direct to the

Mental Health Team mailbox (on outlook) and case note the action they have taken.

- **Telephone Concerns**: People who telephone asking to raise a safeguarding concern or if the social care advisor identifies that there is a possible safeguarding concern, they should first discuss this with the Duty Social Worker, Team Leader or Team Manager, before progressing with creating the concern on CIS. Once advice has been sought the Social Care Advisor can progress with creating the concern on CIS, completing the necessary fields and gathering as much information as possible from the person raising the concern. They then assign this on CIS to the Safeguarding Adult Team or the Mental Health Team (if primary support reason is for mental health) and follow this up with an email to the respective mailbox to alert them of the concern on CIS.

- **No Initial Decision Making**: At this stage, no decisions are made regarding the concern other than recording it on the appropriate person's record and assigning to the relevant team. Information gathering is minimal and only to address any critical missing details necessary for record creation.

**Hospital Team Responsibilities**:

- The Hospital Discharge Team is responsible for receiving any concerns where the abuse or neglect occurred within a Calderdale and Huddersfield Hospital setting. The Hospital Discharge Team is responsible for inputting the concerns on to Safeguarding Adult Stage 1 screens on CIS. The Hospital Discharge Team can give cause to the Hospital Safeguarding Team to undertake the enquiries, however the Hospital Discharge Team retains responsibility for co-ordinating the enquiry and updating CIS as per the processes described below.

**Safeguarding Adult Team, Mental Health Team and Hospital Discharge Team Responsibilities**:

- **Receipt of the concern**: The Team Manager, Team Leader or Practice Lead will receive the incoming concern on outlook (or CIS if initial concern is taken via the phone).
- **Initial Screening:** Decide whether the concern falls within the scope of safeguarding: The Team Manager, Team Leader or Practice Lead will review the information contained within the concern and decide whether or not it falls within the scope of safeguarding. The main question to ask at this stage is

whether or not abuse or neglect is occurring that may require safeguarding enquiries. The three-stage test is not applied at this point.

If the concern is around a 'request for support' (for people who do not have any ongoing care and support in place) or a 'review of support' (for people who do have ongoing care and support in place), then this can be forwarded to the relevant team i.e. Gateway for people who do not have care and support in place or community teams for those who do. If the person subject to the concern has an allocated worker, then they need to be notified. Similarly, complaints (quality or practice issues relating to care providers) can be forwarded to community teams to consider and liaise and resolve and if required copy in ICCQT.

- If the Manager, Team Leader or Practice Lead decides that the initial concern **does** fall within safeguarding then the Safeguarding Adult Team or Mental Health Team need to input the concern on to CIS as a stage one and associate any documents. They then allocate it to a Safeguarding Practitioner within their respective team.
- If the Manager, Team Leader or Practice Lead decides that the initial concern **is not** safeguarding they need to associate records to file and document actions taken on a case note.

## Mental Capacity Act Assessments

Decision Making, Consent and Mental Capacity (opens as a PDF)

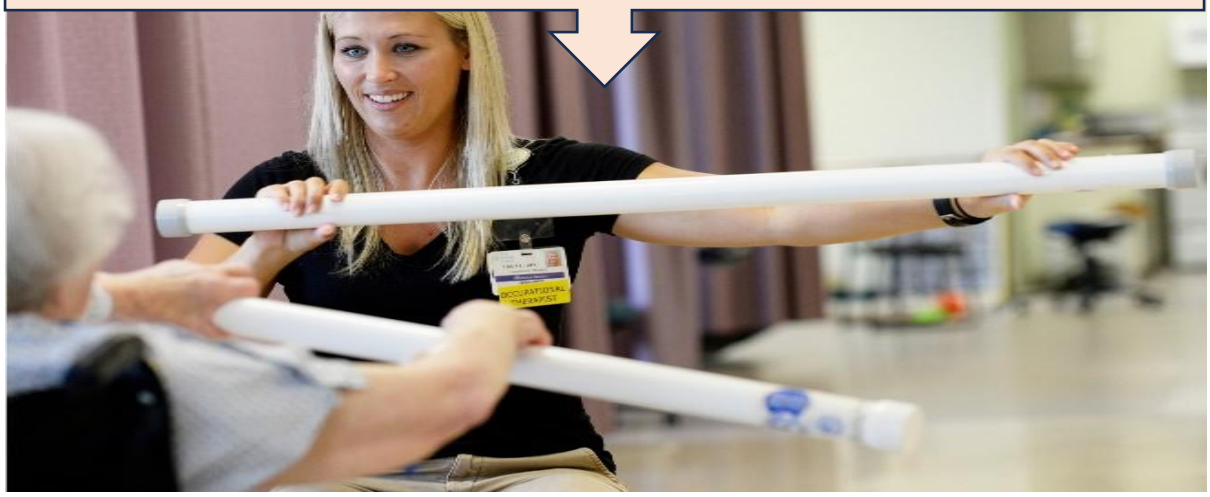
# Pathway 2 Process Map

All assessments to commence no later than 48hrs on receipt of referral. If MCA & Bid needed arrangements should be made within this period to commence these assessments. If nursing placement is identified, then request for FNC to be made to the ICB.

Once assessments are complete and pathway has been confirmed all information must be passed to the Provision Planner to source service. Financial conversation must be had with the person/carer/family/friend on charging and financial bundle given. Only if the person is in need of services that we cannot provide is the bed free of charge for up to 6 weeks. PLAG to be completed and approved in 72 hours where residential services are required.

Once provision planner has sourced a service budget to be approved by Manager. When budget approved the person/carer/family/friend can be informed. Times for POC must be agreed by person/carer/family/friend.

service to be informed of date of discharge TTO's to be arranged and transport. Discharge to take place.



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