Humber Teaching NHS Foundation Trust

STANDARD OPERATING PROCEDURE
HOSPITAL DISCHARGE SERVICE

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Author/Lead **Job Title**	Katie Barraball (Therapy Lead) Rachel Laud (Clinical Lead UCR / Therapy)
Instigated by: **Date Instigated:**	Matthew Handley Community & Primary Care General Manager Kerry Brown – Clinical Lead
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Name of Trust Strategy/Policy/Guidelines this SOP refers to:	IPC Admission Transfer Discharge Policy N-033.pdf (humber.nhs.uk) Infection Prevention and Control Policies (humber.nhs.uk) Admission Process for Community Inpatient SOP19-047.pdf (humber.nhs.uk) Community - Pocklington Hub Beds and Intermediate Care SOP23-018.pdf (humber.nhs.uk)

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*1/11/22*	*New SOP. Approved at Community Services Clinical Network Group 17 November 2022.*
1.1	*18/01/2024*	*Reviewed. Approved by Community Services CNG (18 January 2024).*

Contents

1. INTRODUCTION

Multi-disciplinary hospital discharge teams and transfer of care hubs, comprising professionals from all relevant services across sectors (such as health, social care, housing and the voluntary sector), should work together so that, other than in exceptional circumstances, no one should transfer permanently into a care home for the first time directly following an acute hospital admission. Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.

This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence as soon as possible. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of inpatient care and elective surgery, such as hip replacements.

2. SCOPE

This standard operating procedure (SOP) outlines the role and responsibilities of the Hospital discharge service (HDS). It outlines its key functions and the procedure for contacting the team. The aim of utilising a senior triaging clinician at the point of referral is to free up the capacity of clinicians who are dealing directly with patients within community services. The HDS will co-ordinate and manage the flow of patients from community and acute bedded units into HTFT community services.

3. DUTIES AND RESPONSIBILITIES

Divisional Clinical Leads, General Managers, Service Managers, and Locality Matrons

- Will support the operationalisation of the HDS.
- Will ensure this SOP is disseminated to wards and services within their sphere of responsibility.

Clinical Leads

- Will provide clinical support and route of escalation.
- Will escalate to the locality matrons, therapy lead and/or service managers concerns related to the safe and effective running of the HDS.

Hospital Discharge Service Team

- Will provide a single point of contact (SPoC).
- Will provide a triage service to for all referrals into community inpatient wards and community services from acute partners including step up patients from the community to community wards. Some Specialist Services referrals go via the SPoC team by prior agreement.
- The HDS clinician will review all patients referred into the service and will allocate to the appropriate clinical team.
- The service operates 8-6pm 6 days a week Monday to Saturday.

4. PROCESS

4.1. Patient Flow Process

Referrals are sent from the service discharging the patient to HDS via email on a completed Trusted Assessment Form (TAF): hnf-tr.hospitaldischargeservice@nhs.net

Referrals from the Same Day Emergency Care Unit (SDEC), Elderly Assessment (EAU) and Emergency Departments at Scarborough and York Hospital for inpatient rehabilitation can be accepted via phone call to 01947 899201and submission of completed therapy assessment plus any relevant medical documentation. Referrals from these units to Urgent Community Response are made through the Single Point of Contact.

4.2. Community In Patient Rehabilitation Units

Inpatient rehabilitation is delivered by HTFT at Malton and Whitby Hospitals. Where possible, and the patient fits the admission criteria, referrals from GP and community services for an inpatient bed will be prioritised to prevent an acute admission.

Patients referred into this service are triaged by HDS staff in line with the ward inclusion/exclusion criteria as per the ward admission SOP Admission Process for Community Inpatient SOP19-047.pdf (humber.nhs.uk)

Infection Control Criteria for community Hospitals

Community wards will continue to follow trust policy re infection control guidance. Infection Prevention and Control (humber.nhs.uk)

The majority of patients referred in for in patient rehabilitation step down from acute trusts however in line with the following process step ups from community partners may be accepted into an available bed in line with the above inclusion/exclusion criteria:

1. Referrer contacts HDS with step up enquiry usually via SPOC phone
2. HDS / Single Point of Contact (SPOC) admin will request clinical details and record referral on the clincal system
3. Referral triaged including consideration of UCR response to support the patient to remain at home and if not safe to do so in line with ward inclusion and exclusion criteria. Patients accepted for admission need to have up to date summary care record, medication list and appropriate clinical rationale from the referrer
4. Pre-decision to admit liaise with ward regarding referral. This informs the decision to accept or reject referral. Inform referrer about decision as timely as possible.
5. Follow HDS Sysm1 process for accepting or rejecting the referral

Patients are triaged on an individual basis and where patients fall outside of standard inclusion/exclusion criteria discussion may take place with relevant ward staff/clinical lead/locality matrons if it is felt that it is potentially in the patients interest to be admitted to the ward and where the patient needs can be adequately and safely met by the ward team. In those cases, HDS will comprehensively document the clinical justification from deviating from the criteria and this will be reflected in any subsequent management plan or ceiling of care plan.

4.3. Community Hospital Discharges

The discharges are to follow the same process as discharges from the acute hospital as far as possible with trusted assessment forms completed by the ward and sent to
SCARBOROUGH COMPLEX DISCHARGE LIAISON TEAM
yhs-tr.sghcomplexdischargeliaison@nhs.net

- The community ward is responsible for informing the Humber Hospital Discharge Team about any changes e.g. Delayed Transfer of Care status.
- The ward must update the HDS service daily with any delays to discharge or issues around admission.

4.4. Daily Communication Internally and with Partners

Communication

HTFT Community rehabilitation units are required to submit a daily bedstate to HDS by 8am for reconciliation and communication to external partners by 08.30a.m. Appendix 2 details the bed occupancy and any discharge delays and planned admissions.

In addition there is a national daily sitrep report. Each division has its own Excel file to use. Enter information into the divisional templates only, then save & exit.

V:\Corporate\BI\Public\COVID-19 SITREP\Inpatient Bedstate\01 Monday - 07 Sunday bedstate

This information is collated by HTFT BI team post submission and subsequently distributed by them to relevant parties to reflect the bedstate position for the whole trust.

Continual communication with HDS

All services, particularly Inpatient wards, Intermediate care services must update HDS regarding capacity changes so HDS are informed at all times of any pressure points within community services.
A Monday to Friday daily OPEL report is submitted by all services to HDS inbox to ensure they are informed of any system challenges.

External communication

HDS staff must liaise with partner agencies, when required, as part of support of system wide discharge planning. These meetings may change dependent on Opel scores and pressure on bed capacity within the whole system. There is a daily call at 10:30am, (chaired by Scarborough and the agenda and TOR have been agreed.) that all agencies attend and a representation from the Hospital discharge service should attend to represent Humber trust and escalate any issues to either service managers or matrons dependent on the nature of the escalation.

Reporting on unsafe discharge or poor quality Trusted Assessor Form (TAF):

- Datix unsafe discharges
- Communicate/escalate issues related to unsafe discharges or poor quality TAFs to:

HOSPITAL DISCHARGE REFERRALS (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST) yhs-tr.hospitaldischargereferrals@nhs.net

SCARBOROUGH COMPLEX DISCHARGE LIAISON TEAM (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST) yhs-tr.sghcomplexdischargeliaison@nhs.net

Move email communications to the Inappropriate TAF / Unsafe Discharge folder in the HDS inbox hnf-tr.hospitaldischargeservice@nhs.net

4.5. Off duty

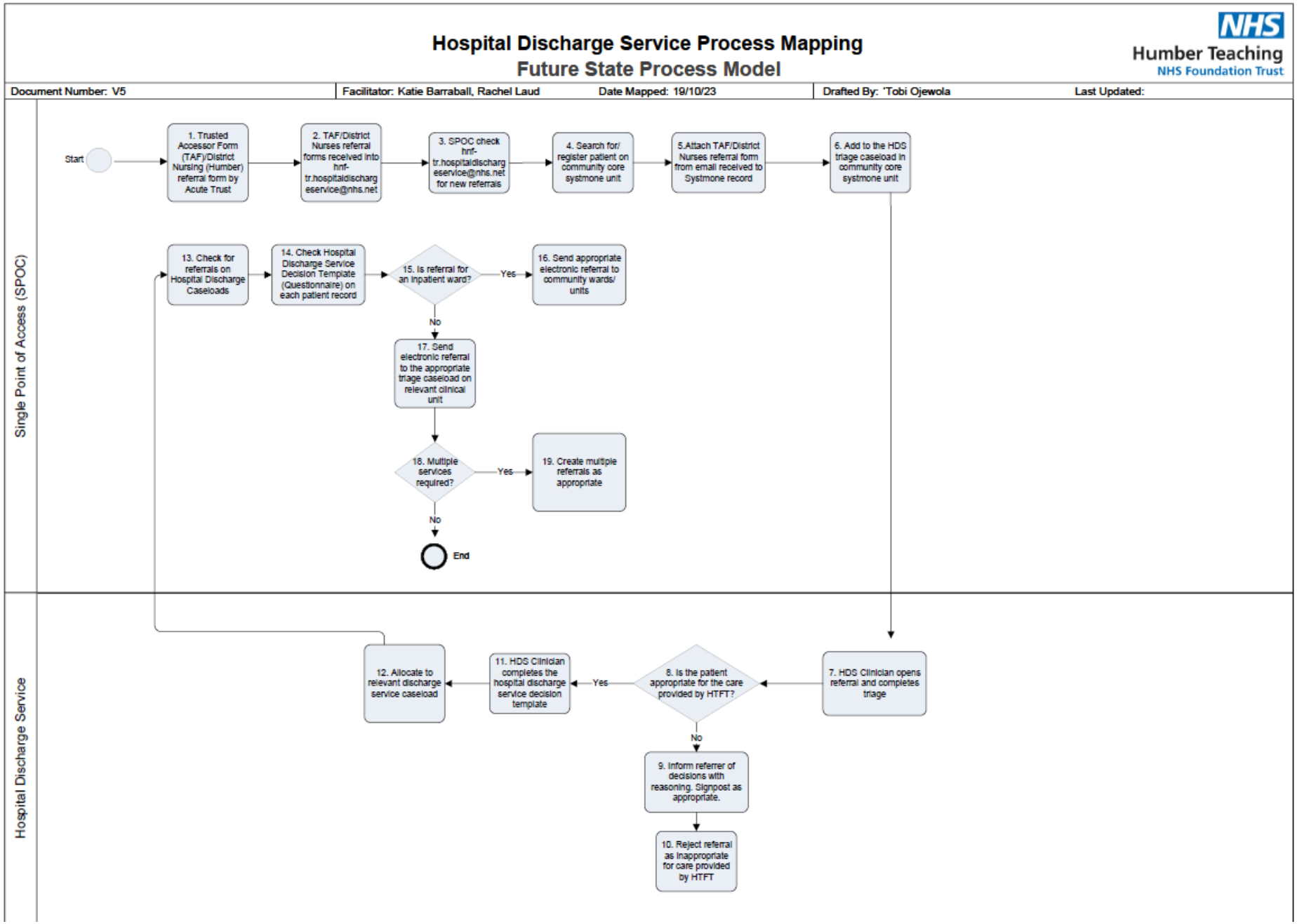
The HDS rota is to be populates 6 weeks in advance. The rota will be populated by HDS staff and final version agreed by Team Leader for this service. The rota must ensure service cover across operating hours within the staff whom are specifically aligned to this service.
V:\PCC\S&R - Scarborough Hub\Shared\Rota\Community Rota Apr 2022 - Mar 2023.xlsm

This rota is in the process of being transferred to E-Roster with an anticipated completion date of 2024

4.6. Business Continuity Plan

In the event of loss of staff or loss of IT systems which impact on the HTFT Hospital Discharge Service actions should be undertaken as per community BCPs which are detailed here V:\PCC\S&R - Community Management\Private\BCPs

APPENDIX 1 - PROCESS MAP HOSPITAL DISCHARGE SERVICE



APPENDIX 2 - MALTON AND WHITBY OPERATIONAL UPDATE

Malton and Whitby Operational Update	NHS Humber Teaching NHS Foundation Trust

Date		**Completed by**	
Time			

For Submission by 8:30 am

Whitby		**Malton**	
Total bed capacity		**Total bed capacity**	
Total patients male		**Total patients male**	
Total side room patients		**Total side room patients**	
Total patients female		**Total patients female**	
Total occupied beds		**Total occupied beds**	
Total blocked beds and rational		**Total blocked beds and rational**	
Total number of vacant beds and gender		**Total number of vacant side rooms**	

Infection prevention

	Whitby	**Malton**
COVID patient details- Including nhs number		
Any other issues (infection control / isolation)		

Patient Flow: (names / NHS numbers)

	Whitby	Malton
Planned Admissions		
Patients to be discharged today- names		
Planned discharges next 3 days		

Patients fit for discharge awaiting discharge date

Name and NHS no (detail what is required for discharge and date TAF submitted)	Whitby	Malton

Operational Overview

Staffing constraints/issues	
Facilities	
Safeguarding DoLs and patients with LD	