Why not home why not today Standard Operating Procedure – Ongoing Care

9th July 2018

The current versions of all policies can be accessed at the NHS Sheffield Intranet Site at http://nww.sheffield.nhs.uk/policies/

Add each organisation link as above

VERSION CONTROL				
Version	**Date**	**Author**	**Status**	**Comment**
1.0	May 2017	Jo Harrison/ Kim Tyler/ Emma Green	Draft	
1.1	June 2017	Jo Harrison/Kim Tyler/Debbie Wade	Amended	
1.2	June 2017	Emma Green / Debbie Wade	Amended	
1.3	8th June 2017	Debbie Morton	Amended	
1.4	9th June	Robert Broadhead	Finalised	
1.5	19th June	Emma Green	Amended	
1.6	15th Aug	Emma Green	Amended	
1.7	4th July			

1. Introduction

1.1 The cohort is relatively small representing only 12% of the total geriatrics discharged from hospital each year.

Currently these individuals trigger via a checklist for a Decision Support Tool [DST] to look at their eligibility for either Health or Social Care funding. Once eligibility of either part or full health care funding or Social Care only eligibility funding from Local authority is known then a package of care is procured to meet the eligible needs by the responsible commissioner, either domiciliary or within a nursing or residential care home. NHS Continuing Health Care (CHC) is a package of care that is arranged and funded by the NHS when a person aged 18 or over is identified as having a "Primary Health Need." - Tracey Grindle

The CHC process in completing a DST involves a lengthy and detailed assessment collection to determine whether a person's needs are 'health' or 'social' related. The assessment process is lengthy and can be stressful, and contentious. Complaints and appeals indicate the need for change to make patients and carer experience more informative and streamlined and equitable for all.

5Q Pilot Report Recommendations

There needs to be an ongoing focus on cultural change across the system supported by strong leadership, with the appropriate behaviours supporting our vison 'Why not home, why not today

There is a workforce development need with regards to appropriately promoting the discharge to assess routes when communicating with the cared for person and families. Role play should be considered as part of the training package.

There is a need for a communication plan aimed at the citizens of Sheffield with the aim of developing an understanding and managing expectations relating to our vison 'Why not Home why not today', to include communicating the key benefits of discharge to assess.

2. Purpose

2.1 The purpose of this document is to detail responsibilities of each organisation/service area to support our vision 'why not home why not today', in relation to the 3 routes out of hospital. (see appendix 1 – flow chart)

3. Scope

This procedure refers to individuals with a requirement for muti-agency input from a NHS bed based resource discharged for an up to 28 day period of assessment in response to a potential funding requirement.

Individuals will be discharged to Route 2 Home to Assess or Route 3 'Somewhere else to Assess' dependant on their presenting needs which dictates whether services are led by social care or health. Individuals receive an up to 28 day assessment period once optimised, as described within the 'National Framework for NHS Continuing Healthcare & NHS-funded Nursing Care'.

This procedure applies to all adults over the age of 18, registered with a registered GP, who would for ordinary residence purposes be the responsibility of Sheffield City Council.

Individuals are identified through the community handover process.
-Need to validate DE/MH

The health and social care system has commissioned an assessment bed resource to provide for somewhere else to assess.

ready for discharge on the day of referral. All Mental for assessment capacity issues and best interest meetings will have concluded at this point. The pathway will run initially for 12 weeks for people who meet the current NRP criteria and are deemed Multi-Disciplinary Team (MDT) fit for discharge. – Revisit 5th July MCA/BI

3.1 Sheffield Clinical Commissioning Group (SCCG) and Sheffield City Council (SCC), Sheffield Teaching Hospitals (STH) will follow respective Safeguarding policies and will adhere to the wider roles and responsibilities in respect of this.

3.2 Individuals subject to section 117 (117) aftercare funding arrangements (Mental Health Act (MHA 1983) do not sit within the scope of this procedure.

3.3 All staff involved must have a working knowledge of the associated policies, procedures and processes.

3.4 All staff must be compliant with the MCA (including Best interests) code of practice throughout this pathway as required.

3.5 This document relates to the following specific groups with direct key roles in the implementation and delivery of this process. All operational staff are responsible for escalating concerns and risks to the appropriate level.

3.5.1 **Head of Service**

They are responsible for the oversight of the standard operating procedures and facilitating all operational requirements and identifying risks and developing mitigating actions to minimise these risks.

3.5.2 **STH Operational Lead, Transfer of Care team (TOC)/Intermediate Care**

The operational lead is responsible for ensuring that all staff are conversant with this standard operating procedure, they will ensure staff compliance. They will be aware of and ensure implementation of the processes and actions that are required to be taken in relation to the individual*, the* completion of assessments and appropriate care plans. These will be shared with the provider and SCC and CCG. They will ensure that all their staff are aware of their responsibilities.

3.5.3 SCC Team Managers/SCCG Operational Lead (CHC) - Community

The SCC Team Manager/SSCG Operational lead is responsible for ensuring that all staff are conversant with this standard operating procedure, they will ensure staff compliance. They will be aware of and ensure implementation of the processes and actions that are required to be taken in relation to the individual. They are responsible for allocation of 'individuals cases to workers that will pick up the case and work on it within agreed timeframe up to 24-72 hours(excluding weekends and bank holidays)

3.5.5 Business Support Teams (BST)

They are responsible to ensure the flow of information is timely accurate and recorded on the relevant systems in line with GDPR. They are responsible to ensure that financial processes are set up, maintained and discontinued as necessary. Also to ensure the information is accessible to key stakeholders as and when required.

3.5.6 Single Point of Access (SPA)

They are responsible for implementing all agreed out of hours arrangements as the per service specification.

4 Key Definitions

4.5 The following definitions are specifically referred to in this Operating Procedure.

5 Standard forms and guidance on completion

5.5 The standard forms to be used in this process are;

- Generic Triage Tool
- Request for Service form (RFS) - Care plan with consent statement
- Care plan (relating to NHS domiciliary care provision)

- Activity of daily living form (ADL)
- Contact assessment
- F3 contract for SCC Residential Care placements

6 Contact Details

Transfer of Care (TOC) Team

Operational lead, Transfer of Care Team
0114 2266999

Transfer of Care Admin
0114 2715078

Intermediate Care Beds
Operational Lead
0114 2261760

Sheffield City Council
Service Manager (Community)
0114 2734960

Adults Social care teams
0114 2734960

Sheffield City Council BST
BST Manager 0114 2930607

Sheffield Clinical Commissioning Group

CCG BST
Duty Line – 0114 3051700

CHC Head of Service
0114 3051700

Sheffield City Council Head of Localities
0114 2735891

Single Point of Access (SPA)
0114 3051460 – Tracey Grindle

6.5 Criteria

The following requirements are set out below:

- Use the same narrative as in the introduction

Cases will not be appropriate if funding arrangements are already in place and continue to meet the person's needs.

5Q cases – Check and Challenge D Wade/P Hague 5Q Tracker

6.5.3 For cases where the individual is MDT fit for discharge and would be normally subjected to a checklist to our existing NRP pathway, but excluding those that are documented in the section above:

- MDT/Ward identifies individuals for the Hospital 5Q.
- TOC team complete 5Q test to determine which pathway route (Social care or NHS and destination – home or residential based placement) and complete care plan and care requirements
- TOC team arrange discharge with CCG home care provider and make all necessary arrangements for primary/community services and equipment
- TOC to contact District Nursing Team as necessary. All relevant information is under 'record attachments' on SystmOne. If unable to contact District Nurse via phone, to send task to Team Leader/Community
- The providers must advise the relevant care manager of any 5Q individual readmitted to Hospital. The care manger must inform TOC so they can be tracked.
- The TOC team can fax Horizon care on the main line and this will then drop into email inbox to print securely. TOC team to use between the hours of 9:00-5:00 Monday – Friday the mobile number **07904876430** for direct contact. Outside of these hours they will ring **07572342830** to be picked up by the Clinical team on duty each shift.
- For people going home, TOC to update person and family with appropriate contact number dependant on NHS or Social Care pathway

6.1.2 NHS Referral Route

Destination home

- TOC to send Care plan and Request for Service Form (RFS) to CHC via SystmOne e-referral **using SystmOne (S1) referrer status of 5Q Social Care or 5Q NHS**

- CHC BST accepts the referral and sends to the appropriate provider according to geographical area.

  Subject to meeting DW Chair

  Need to number not bullets review also separate SoP for each service area in relation to the below part of the community handover

  Split by service are like triage tool visio approach

  Transactional process, obligations and responsibilities request for each service area to send. TASK Team develop to include COD

- CHC procure care package immediately discharge must be within 48-72 hours
- The nominated provider will implement the agreed care package within 48 hours
- CHC BST inform TOC of discharge date via SystmOne Task and a phone call
- TOC to inform ward of discharge date to confirm transport
- BST to ensure that data metrics are updated throughout the referral process.
- TOC to telephone District Nursing team (DN) to provide the relevant information about individual as appropriate complete referral form and send via SPA, and update SystmOne journal.
- CHC Team Leader (TL) allocate case on SystmOne to nurse assessors/care manager with due date of visit, set within the 48-72 hours of discharge
- The provider will formulate care plans and all other records as required to ensure safe and consistency and appropriate care is delivered and utilising the care plan from the STH whilst production of their own care plan within 48 hours (excluding weekends for domiciliary)
- CHC to visit individual, and review care plan and records within 48-72 hours (excluding weekends) preferably within 48 hours, advise BST for data metric updating purposes.
- CHC BST log on QA and trigger appropriate payment processes dependent upon whether individual is funded via 5Q Social Care (domiciliary care) or 5Q NHS referral

- The Nurse assessor/care manager will within 15 days review the care and support including documentation and care plan. The care manager will make adjustments to the care package as necessary and actively manage the case. They will decide whether the individual is optimised to be considered for eligibility for CHC funding. If at this point they consider the individual is optimised they will arrange for a DST to be completed by day 21 (hence within 6 days of midpoint review)

- For both nursing beds and domiciliary care pathways –if no CHC needs identified then Case manager to complete checklist to show screen outs for DST.

- If likely to require checklist move to straight to DST.

- If the individual is considered not optimised no decision will be made at this point, the nurse care manager will review the individual on a daily basis. This will need to be captured with the BST team as an exceptionality due to ill health.

- At the point the case manager reviews the individual and decides if they are optimised either to screen out via checklist or arrange DST before day 21

- If the checklist is negative then a copy of the checklist is to be sent to CHC BST for saving as this is a requirement for the framework compliance, and a copy is sent to social care BST to action for social care assessment

- Data will be captured as required and agreed for this pilot

Destination Interim Short Term Care placement – NHS pathway

- TOC/ Care home placement team will check bed availability and complete the Request for Service (RFS) and Activity of Daily Living form (ADL)- care home placement at STH to place and send all relevant documentation to the care home via agreed method.

- Equipment ordering/in place in person home/residential

- TOC to inform ward staff to arrange and book transport

- TOC to advise CHC team of standard placement, discharge date via Request for Service Form (RFS)

- CHC BST log on electronic system (QA) and trigger appropriate payment processes

- CHC TL allocate case on SystmOne to nurse assessors/care manager with due date of visit, set within the 48-72 hours

- CHC to visit patient, and review care plan and records within 3 days (excluding Saturday and Sunday)

The Nurse assessor/care manager will within 15 days review the care and support including documentation and care plan. They will decide whether the individual is

optimized to be considered for eligibility for CHC funding. If at this point they consider the individual is optimized they will arrange for a DST to be completed before day 21.

- CHC to review/assess as per standard practice
- If the individual is considered not optimized no decision will be made at this point, the nurse care manager will review the individual on a daily basis.
- At the point the case manager reviews the individual and decides they are optimised either to screen out via checklist or arrange DST before day 21
- If the checklist is negative then a copy of the checklist is to be send to CHC BST and a copy is sent to social care BST to action for social care assessment
- For both nursing beds and domiciliary care pathways – if no CHC needs are identified, then Case manager is to either complete a checklist to show the individual screen outs for DST or to include a statement that the individual has been looked at and do not require any further health assessment and therefore a checklist is not needed. The CCG will require a copy of this statement for their records. If the individual is likely to require a checklist and would screen in move to straight to completion of a DST.

Destination Interim Short Term Care Home placement - Social Care Pathway

- TOC/ Care home placement team will check bed availability and complete the Request for Service (RFS) and Activity of Daily Living form (ADL)- care home placement at STH to place and send all relevant documentation to the care home via agreed method.
- Equipment ordering/in place in person home/residential
- TOC to inform ward staff to arrange and book transport
- TOC to advise CHC team of discharge location for data recording purposes.
- TOC to advise Social care of discharge
- Social worker does short term F3 contract: social worker care management for 28 days
- Regarding the F3 & financial assessment - we will only charging the client from the point that the offer of care is given.
- SCC allocated worker to advise CHC date F3 completed for data metric purposes
- Care manager to establish which District Nursing Team to liaise with by contacting SPA

- For residential care – if no CHC needs identified then Case manager to complete a checklist to show the individual screens out. If likely to screen in on a checklist care manager to contact Duty Line at CHC to arrange DST date

- If the individual is considered not optimized no decision will be made at this point, the care manager will review the individual on a daily basis.

Destination: Home that are likely to be eligible for social care only:

Referral will be received from the Transfer of Care Team (TOC) in the same way that NRP referrals are received but will be flagged as 5Q. This will include the individual's home address and contact details, the name, address and contact details of family involved in the individuals care and the name and contact details of the provider (including providers OOH contact details) and the discharge support plan.

- TOC to send Care plan and Request for Service Form (RFS) to CHC via SystmOne e-referral **using SystmOne (S1) referrer status of 5Q Social Care or 5Q NHS**

- CHC BST accepts the referral and sends to the appropriate provider according to geographical area.

- CHC procure care package immediately discharge must be within 48-72 hours

- The nominated provider will implement the agreed care package within 48 hours

- CHC BST inform TOC of discharge date via S1 (via Task and journal entry)

- CHC to communication with SCC BST of impending discharge and ascertain care manager allocated for discharge and oversight.

- TOC to inform ward staff to arrange transport

- BST to ensure that data metrics are updated throughout the referral process.

- TOC to telephone District Nursing team (DN) to provide the relevant information about individual as appropriate complete referral form and send via SPA, and update SystmOne journal.

- TOC confirm discharge date with CHC via BST and SCC BST.

- TOC to send 5Q. Referral For Service form , Contact assessment , MAR Chart and ADL documentation

SCC will use Postcode finder to identify potential domiciliary care provision pending handover of care provision up day 28.

SCC will allocate the same working day (there will be a 2pm cut off for referrals-those referrals received after 2pm will be deemed to have been received the next working day.

All referrals will be logged

The allocated assessor will contact the person/family and provider to arrange an assessment visit within 48-72 hours of allocation (staff in the NRP team/localities will need to maintain free slots in calendars to facilitate this speed of response).

The provider will ensure 24 hour care logs are present in the person's home to support the assessment of need

If it becomes apparent that the person does not meet the threshold for a CHC assessment, a statement will be completed for this rational to show no apparent need for health referral.

If the social care assessor identifies there is a health need they must communicate with CHC to arrange a DST.

The social care assessor will discuss charging for social care and use the financial assessment tool to inform the person of the amount of discount they will receive and an indication of what they will need to pay.

If long term needs are clear at this stage the social care assessor will complete their assessment and this can be authorised in CareFirst by their line manager;
Strengths and asset based
Eligible needs/outcomes clearly evidenced
Proportionate

Where a carer's assessment is requires the assessor will refer the carer(s) to the Sheffield Carers Centre who are under contract to carry out this function on behalf of SCC

Copy of needs assessment sent out to the person/family

If the persons long term needs are not clear at this stage (person/provider could be indicating increasing independence or dependence)

The SCC paperwork -AQ/RQcompletion would be delayed until day 14 at the latest but Commissioning would need to be asked to start looking for a home care provider using the Bluebird/Abbey support plan as a guide after the first home visit and using that to complete a service amendment form (SAF) with an asap start date. The assessor will also complete an F1A for the social care accounts service (SCAS) both documents to include the wording "5Q pilot discharge please prioritise."
Introduction of just checking-where the social care assessor/provider is unclear regarding relevant behaviour patterns-just checking could add evidence for the needs assessment.

Day 4-day 8 post discharge (long term needs are clear) or day 15-day to day 19 post discharge (where long term needs are not clear)

The social care assessor will then complete a support plan and MCA if required (inc Re:X consideration) and seek authorisation in line with the adult social care decision making guidance and a PRF generated and completed as well as a F1A to trigger the financial assessment. Both documents to include the wording "5Q pilot discharge please prioritise."
Care Management Responsibility

The allocated social care assessor holds care management responsibility from allocation until sufficiently stable to transfer to review

If upon receiving a social care package, and an increase is needed, a care plan will be updated and the CCG provider will be contacted by social care and the care package amended. The CHC BST will be made aware, with a copy of the revised care plan and start date to enable record keeping and data metrics.

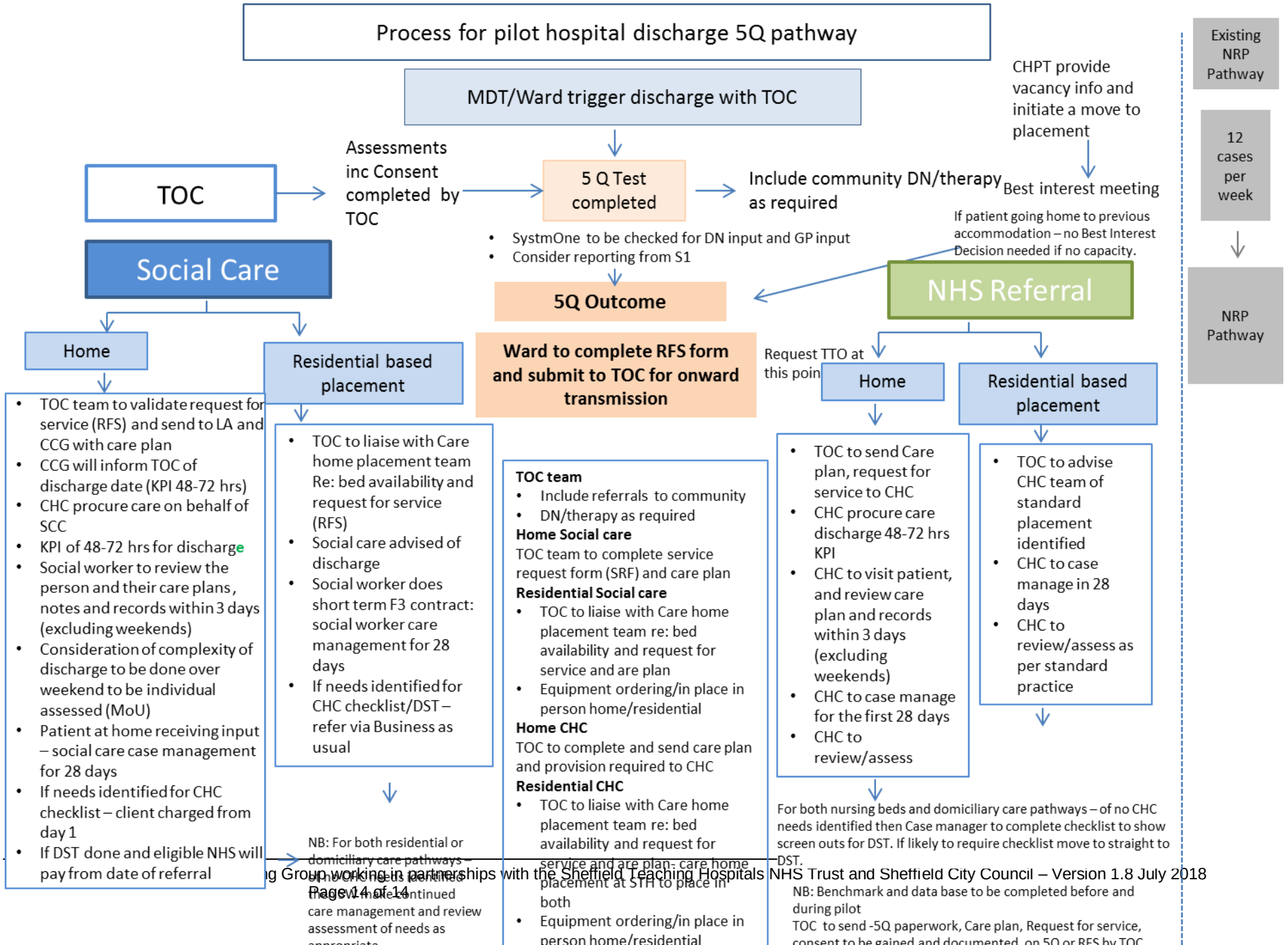
Data Metric Requirements D Wade 5Q Tracker

- All participating organisations are committed to ensure that information relating to the patient flow is communicated in a timely manner to CCG BST, who are maintaining and updating the data metrics for both 5Q pilot patients and current NRP patients.

- The reliance on the data metrics being fully completing will assist the evaluation of the pilot and ongoing review.

12 month reviews to be scheduled.

Appendix 1 Process for pilot hospital discharge 5Q pathway


Process for pilot hospital discharge 5Q pathway
MDT/Ward trigger discharge with TOC
TOC
Assessments inc Consent completed by TOC
5 Q Test completed
Include community DN/therapy as required
CHPT provide vacancy info and initiate a move to placement
Best interest meeting
If patient going home to previous accommodation – no Best Interest Decision needed if no capacity.
SystmOne to be checked for DN input and GP input
Consider reporting from S1
5Q Outcome
Social Care
NHS Referral
Home
Residential based placement
Ward to complete RFS form and submit to TOC for onward transmission
Request TTO at this poin
Home
Residential based placement
TOC team to validate request for service (RFS) and send to LA and CCG with care plan
CCG will inform TOC of discharge date (KPI 48-72 hrs)
CHC procure care on behalf of SCC
KPI of 48-72 hrs for discharge
Social worker to review the person and their care plans, notes and records within 3 days (excluding weekends)
Consideration of complexity of discharge to be done over weekend to be individual assessed (MoU)
Patient at home receiving input – social care case management for 28 days
If needs identified for CHC checklist – client charged from day 1
If DST done and eligible NHS will pay from date of referral
TOC to liaise with Care home placement team Re: bed availability and request for service (RFS)
Social care advised of discharge
Social worker does short term F3 contract: social worker care management for 28 days
If needs identified for CHC checklist/DST – refer via Business as usual
NB: For both residential or domiciliary care pathways – if no CHC needs identified then SW make continued care management and review assessment of needs as appropriate
TOC team
Include referrals to community
DN/therapy as required
Home Social care
TOC team to complete service request form (SRF) and care plan
Residential Social care
TOC to liaise with Care home placement team re: bed availability and request for service and are plan
Equipment ordering/in place in person home/residential
Home CHC
TOC to complete and send care plan and provision required to CHC
Residential CHC
TOC to liaise with Care home placement team re: bed availability and request for service and are plan- care home placement at STH to place in both
Equipment ordering/in place in person home/residential
TOC to send Care plan, request for service to CHC
CHC procure care discharge 48-72 hrs KPI
CHC to visit patient, and review care plan and records within 3 days (excluding weekends)
CHC to case manage for the first 28 days
CHC to review/assess
TOC to advise CHC team of standard placement identified
CHC to case manage in 28 days
CHC to review/assess as per standard practice
For both nursing beds and domiciliary care pathways – of no CHC needs identified then Case manager to complete checklist to show screen outs for DST. If likely to require checklist move to straight to DST.
NB: Benchmark and data base to be completed before and during pilot
TOC to send -5Q paperwork, Care plan, Request for service, consent to be gained and documented on 5Q or RFS by TOC
Existing NRP Pathway
12 cases per week
NRP Pathway