EAST RIDING OF YORKSHIRE COUNCIL

East Riding of Yorkshire Council

Discharge to Assess (D2A)

Pathway Guidance

Standard Operating Procedure

Version 5

Document Control

Version Number	Issue Date	Reason for Issue
1	01/04/2020	Initial drafts for development/comments.
1.1	04/04/2020	Re draft for further amendments
2	06/04/2020	Version 2 for dissemination approved by HoS, Strategic Leads, and Service Managers.
3.	20/04/2020	Draft document with comments received from Performance, CSS, CWT and HSW/EHT teams.
4.	05/05/2020	Revised for circulation.
5.	12/05/2020	Revised for circulation.

Document Purpose

The purpose of this document is to support the COVID-19 hospital discharge service requirements whereby unless a patient requires to be in hospital they should not remain in an NHS funded hospital bed. This process is known as the Discharge to Assess Pathway.

When classified as medically ready for discharge by the acute hospital trust, the trusted assessor paperwork will be completed on the Ward. The pathway decision, in relation to all pathways except 0, should be made in partnership between the community health services provider including input from adult social care representatives. The most appropriate pathway based on the patient's presentation/needs will be identified to facilitate discharge. Occasionally there may be movement (after discharge) across other pathways as part of the review of needs.

There are separate processes for all pathways, as outlined by HM Government and NHS guidance 'Covid19 Hospital Discharge Service Requirements' published 19 March 2020, as follows:

Pathway	Description
0	A simple discharge home from hospital with no input from health and or social care.
1	Support to recover at home; able to return home with support from health, and or social care.
2	Rehabilitation/reablement in a bedded setting.
3 (includes Pathway 4* at York Teaching Hospital Trust)	There has been a life changing event and Home is not an option at the point of discharge i.e. temporary residential/nursing care. (*York Teaching Hospital Trust have split Pathway 3 to include a Pathway 4 for EOL/complex CHC needs)

Discharge to Assess Pathway – High Level Overview

ALL ACUTE TRUST WARDS IDENTIFY MED FIT AND UNDERTAKE TRUSTED ASSESSOR ASSESSMENT

MDT decides Pathway for patient

ASC WORKER

(SW/ SSW/ TM/) Has input into pathway decision

OT may have input to support reductions or consider alternative care and support requirements

PATIENT MOVED TO ACUTE DISCHARGE SETTING within 1 HOUR OF MED FIT and to be DISCHARGED within 2 HOURS AFTER CONFIRMATION OF PROVISION.

ASC OUT OF HOSPITAL HUB (Virtual)
Wards Trusted Assessor forms received and actioned by CSS TA/HSW – **2 hours** timeframe to mobilise care and support ready for hospital discharge.

Out of Hospital Hub - KEY ACTIONS:

- Checking CSS capacity, if none, Call Out to private Providers – **30 minutes response time**
- ASC worker to check Community bed capacity as Plan B if private provider has no capacity.
- POC outcome identified – notify relevant Acute Trust Discharge Hub
- OT involvement considered at LTA, refer if necessary

Pathway 1a:

HOME with POC

CSS provision

Capacity known ASAP

Pathway 1b:

HOME with POC

Private Provider

Capacity known within 30 minutes

Pathway 1c:

HOME via Community Bed if POC unavailable

CSS TA or ASC worker to inform Discharge Hub of need for bed

(CHCP organise for HUTHT 01482 247111 and EHT/ASC workers organise for other Acute Trusts)

Pathway 2: Acute bed

Straight to Discharge to assess bed - with ERYC hospital SW oversight

Pathway 3 (including Pathway 4 for York Teaching Hospital)

ERYC hospital SWs source basic residential/nursing beds and have oversight of all restarts.

Pathway 4/York for EOL/CHC

WITHIN 24 – 48 HOURS

CSS AO's UTILISE D2A ASSESSMENT (LTA Form) TO REVIEW INITIAL TA CARE AND SUPPORT

CHANGE

YES:

NOTIFY C&RT/CLOSE INITIAL D2A ASSESSMENT

RAISE CONTACT TO CWT

NO: NOTIFY DESIGNATED SW TO RAISE CONTACT TO CWT FOR REVIEW

INITIATE ASC FINANCIAL ASSESSMENT CONTACT PROCESS

CWT FOLLOW UP/REVIEW within **max**. 12 weeks after NEW D2A CONTACT RECEIVED

Section 1 - Hospital Discharge

1. **Acute Settings Pre Discharge**:

1.1 Based on defined criteria, acute/community trusts must discharge all patients as soon as clinically able to do so. Transfer from the ward should happen within one hour of that decision to a designated discharge area in each acute trust. Discharge from hospital should happen as soon as possible after that, normally within 2 hours for the majority of patients in line with the guidance from HM Government.

1.2 **Transport from hospital -** Upon discharge from acute hospitals, individuals transport home from the hospital discharge setting will be organised by each acute trust as part of their discharge home.

1.3 **Discharge Planning – acute staffing and hospital social work teams:**

1.4 A trusted assessor form will be completed by acute trust Ward staffing and will be forwarded to the command centre/discharge liaison hub at each acute hospital Trust, for review by a multi-disciplinary team (MDT). The MDT role will be to determine the appropriate pathway for discharge, this will include oversight/input from a dedicated adult social care lead, and support provided by a social care OT as identified.

1.5 The trusted assessor form should be sent, by the acute trust, to the appropriate adult social care worker inbox:
HUTHTD2A@eastriding.gov.uk for Hull and Castle Hill Hospitals
enhancedhospital@eastriding.gov.uk for York, Scarborough and Bridlington Hospitals
NLAGD2A@eastriding.gov.uk for North Lincolnshire and Goole Hospitals including Doncaster and Scunthorpe

1.6 All emails should be titled '**Discharge to Assess'**.

1.7 The admin/hospital social work team will add an initial contact to AIS (Adult D2A Assessment), adding a contact allocated to the hospital social worker team. This enables the adult social worker to undertake fact finding to provide a triage function into the pathway decision.

1.8 This also enables the hospital social worker teams to have general oversight of **all** patients being discharged from hospital helping to maintain appropriate adult social care governance and mitigate any potential risks.

1.9 Dedicated social work leads based within each acute hospital trust will ensure that an excel spreadsheet of all D2A individuals identified and discharged are collected daily, to support performance/funding validation processes. These should be saved securely to the delayed transfers of care folder on the teams B drive.

1.10 To co-ordinate discharge for East Riding residents, once the pathway decision has been determined in the relevant acute trust command centre/discharge hub, the adult social care dedicated lead will then instruct admin/hospital social workers to initiate the work flow of the intended hospital discharge **within 1 hour**, in line with the acute trust discharge process as identified within the national hospital discharge service guidance. This will be work flowed to:

1.11 If Pathway 1 – home with a package of care – workflow to Community Support Services and email the trusted assessor form via the CSS TA inbox (starsta@eastriding.gov.uk) with the subject titled **'Discharge to Assess'. See progression through Pathway 1 at Section 4 (page 6).**

1.12 If Pathway 2 – rehabilitation/reablement – after allocation by the dedicated adult social care lead senior social worker, the adult social care team will progress to referral and then undertake a D2A hospital assessment. **See progression through Pathway 2 at Section 5 (page 8).**

1.13 Pathway 3 (including Pathway 4 at York Hospital) – residential/nursing care – after allocation by SSW, the adult social care team will progress to referral and then undertake a D2A hospital assessment. **See progression through Pathway 3 at Section 6 (page 8).**

Section 2 – Adult Social Care 'Out of Hospital Hub' (virtual)

2.1 The purpose of the 'Out of Hospital' Hub is to utilise a multi-disciplinary approach to ensure that people who are being discharged home from hospital on each pathway have their immediate care and support needs identified, organised and delivered in a safe, timely and effective manner.

2.2 The Out of Hospital Hub team consists of the following roles, which will be utilised as appropriate at any point in the discharge to assess process, contact is made via usual team numbers:

- Community Support Service Technical Assistant (CSS TA) , BMC
- Contract and Review Team Officer (C&RT), BMC
- Social Worker (SW), Adult Services (all teams)
- Care Co-ordinator (Care Co), Adult Services (all teams)
- Community Support Service Assessment Officer (CSS AO), BMC
- Occupational Therapist Assistant (OTA) or Occupational Therapist, Adult Services

2.3 The Out of Hospital Hub supports the discharge to assess process 8am to 8pm, 7 days per week but with a cut off point for trusted assessor referrals by 5pm*. (*5pm to be reviewed if/as demand increases). Brokerage team (C&RT) will also work 7 days per week, and is operational 08.00am – 5.00pm daily. The community support service is the lead co-ordinator for Pathway 1 discharges* (*this includes palliative care home with pocs but must have a shortened review date to enable the CWT care and support assessment takes place quickly).

2.4 Upon receipt of each individual acute hospitals trusted assessor form, the following processes will be followed by the identified roles as part of the adult social care 'Out of Hospital Hub'.

Section 3 - AIS recording new and existing clients – all hospital discharge pathways

3.1 In line with data capture and recording processes required as outlined in the Covid19 hospital discharge service guidance requirements, a new process for recording has been developed for all pathways on AIS. This will enable accurate identification of those individuals who will require financial assessments.

3.2 Simple overview of new and existing clients process flows on AIS:

D2A Hospital - Overall AIS - Process

Section 4 – Pathway 1

4.1 The Community Support Service (CSS) team should aim to co-ordinate, provide and or arrange care and support provision as quickly as possible in order to support the acute hospital trusts ability to facilitate discharges - usually within a **2 hour period.** Ensuring accurate, timely recording (opening and closing of assessments/contacts, including), scanning and storage of all relevant documents.

4.2 **Pathway 1 - processes defined:**

4.3 **Step 1** – **In the first instance** upon receipt of the trusted assessor form (either from an acute hospital Trust and or hospice setting), the CSS TA will review CSS rota capacity to identify if sufficient capacity available to enable the provision of a temporary package of care, to facilitate timely discharge from hospital.

4.4 If CSS **has capacity** (and the patient is not prescribed Warfarin/PEG/Stoma care**)**, the CSS TA will then notify, via email, the relevant acute trust discharge hub both to the designated social worker (below) and the dedicated acute trust discharge hub inbox:

Designated social work lead(s)	ASC Discharge Hubs email
Juliet.braund@eastriding.gov.uk Charlotte.aziz@eastriding.gov.uk Tina.cade@eastriding.gov.ik Donna.hudson@eastriding.gov.uk	HUTHTD2A@eastriding.gov.uk
Penny.ainley@eastriding.gov.uk Karin.cooper@eastriding.gov.uk Nicola.mawdsley@eastriding.goc.uk Kimberley.philps@eastriding.gov.uk Ryan.evans@eastriding.gov.uk	enhancedhospital@eastriding.gov.uk
Marianne.swaine@eastriding.gov.uk	enhancedhospitals@eastriding.gov.uk
Sarah.himsworth@eastriding.gov.uk Nicole.fowler@eastriding.gov.uk Nicola.sherburn@eastriding.gov.uk	NLAGD2A@eastriding.gov.uk

4.5 The email should outline the individuals NHS number, the availability of the relevant care and support and the times when the package of care will commence. The acute trust discharge hub will then be able to follow their own internal processes to facilitate discharge.

4.6 The CSS care and support provision will then meet the discharged individual at their home.

4.7 Immediately, the CSS TA/CSS assessment officer will then liaise with the contract and review team officer (C&RT), raising a CERT indicating that the purpose of provision is **'hospital discharge**' and sending via email (to: contractors@eastriding.gov.uk).

4.8 This initiates a 'call off' process utilising the independent care and support provider market. These call offs should be urgent and ongoing until an offer is received, in order to free up CSS capacity for future hospital discharges.

4.9 **Contract and Review Team (C&RT) – commissioning pre provision of packages of care**:

4.11 C&RT, upon receipt of an offer of re provision from an independent care and support provider, will contact the relevant community wellbeing team (CWT) duty inbox to inform of offer and commencement date.

4.12 CWT SW/CC will contact individual with the offer and should respond/inform C&RT if accepted/not accepted. If not accepted, C&RT will continue to pursue until an offer is accepted by individual.

4.13 If individual accepts offer, CWT inform C&RT, who will inform CSS (STARSTA email) and will award CERT to private provider.

4.14 C&RT will update AIS Case Notes of every step they have taken/responses etc.

4.15 This frees up CSS provision to further support hospital discharges and enables on going care and support provision to commence. The independent care and support provision will then meet the discharged individual at their home on the agreed commencement date.

4.16 **Step 2** - If CSS **does not have** capacity, in the first instance (and also <u>always</u> for people who <u>are</u> prescribed Warfarin/PEG/Stoma care). The CSS TA will then need to liaise with the contract and review team officer (C&RT), via email sending a completed CERT (contractors@eastriding.gov.uk), initiating a 'call off' process utilising the independent care and support provider market. Independent providers should be given a maximum of **30 minutes** to respond as per Rapid Response Model.

4.17 **Step 3** – **Secondly and immediately after undertaking Step 2**, the CSS TA will email a request to the designated Out of Hospital Hub Care Co to review the available community beds capacity, (received once daily AM) (This could be reviewed accordingly depending on demand.) whilst awaiting receipt of any response(s) from the call off process. This will enable a responsive contingency in the event of no availability or lack of response by the independent care and support sector. (Appendix 5 Community Beds).

4.18 **Step 4** - If C&RT officer receives a provider response informing <u>they have availability</u> for the request of a package of care, the C&RT officer, copying in the CSS TA, should immediately notify the acute hospital trust discharge hub designated social work lead and discharge hub inbox (as above point 4.4), who will then inform the acute hospital discharge hub.

4.19 The independent provider care and support provision will meet the discharged individual at their home, at the agreed commencement of service.

4.20 **Step 5** - If C&RT officer does not receive any response at the end of the **30 minute period,** they must notify the ASC worker, who will inform the relevant acute trust Discharge Hub to organise a move to a community bed to free up CSS rota capacity (copying in the CSS TA, ensuring live communication flows).

4.21 C&RT will continue to prioritise liaison with the independent care and support providers via call off process until appropriate provision is found.

4.22 **Repeat Step 4:** If C&RT officer receives a provider response informing they have availability for the request of a package of care, the C&RT officer, copying in the CSS TA, should immediately notify the acute hospital trust discharge hub designated social work lead and discharge hub inbox (as above point 4.4), who will then inform the acute hospital discharge hub.

4.23 AIS recording process:

a) If CSS have capacity:

D2A Hospital - CSS Only - AIS Process M

b) If CSS do not have capacity:

D2A Hospital - Hospital Teams Only

Section 5 - Pathway 2:

5.1 The Hospital and EHT social work teams should aim to have oversight of all patients being discharged directly to community beds and undertake a review of the trusted assessor form before AIS recording/updating and contact is made to community wellbeing teams **within a 2 hour** (HUTHT) or **3 hour** (York and Scarborough) period.

5.2 The adult social worker is responsible for recording/updating AIS and Case notes, informing of the potential to charge for a service after the emergency period has ended and the persons' long term needs have been identified. Sending out the financial letter and signature sheet, requesting these to be returned to the relevant CWT Duty worker for processing and initiating contact to the welfare rights team.

5.3 Then raise a contact to the community wellbeing team.

5.4 AIS recording process

D2A Hospital Pathway 2+3 - Overa

Section 6 - Pathway 3 (and 4 for York Hospital Trust):

6.1 The hospital social worker will ensure that any residential or nursing home requests for pathway three are sourced, with identified costs and sent to the dedicated social care lead (TM/SSW) for approval.

6.2 The dedicated social care lead will approve the placement and the adult social worker will inform the command centre/discharge liaison Hub of details to facilitate discharge within a 2 hour (HUTHT) or 3 Hour (York and Scarborough) period.

6.3 The adult social worker is responsible for recording/updating AIS and Case notes, informing of the potential to charge for a service after the emergency period has ended and the persons' long term needs have been identified. Sending out the financial letter and signature sheet and initiating contact to welfare rights team.

6.4 Then raise a contact to the community wellbeing team.

6.5 AIS recording process

D2A Hospital Pathway 2+3 - Overa

Section 7 - Follow on support – all hospital discharge pathways

7.1 D2A Review - The initial trusted assessor hospital discharge care and support provision must be reviewed, between 24 and 48 hours, of the individual leaving hospital by:

7.2 **Pathway 1:**

a) With a package of care provided by CSS. A CSS assessment officer will use the D2A Assessment (LTA form) (Appendix 6 D2A Assessment (LTA form), to determine whether it is appropriate to continue the initial trusted assessor D2A support identified, or whether any modifications of the package is required. An initial overview of capital limits for potential future charging should be had with the person at this point, outlining that no charging will be applicable throughout the national emergency period but may occur after long term needs have been reviewed.

b) If CSS have no capacity and an Independent Provider provides the care and support package an adult social care worker will utilise the Adults D2A Assessment on AIS to determine whether it is appropriate to continue the initial trusted assessor D2A support identified or whether any modifications of the care package is required.

7.3 **Step 1 – No change** - At this point, the Out of Hospital Hub CSS assessment officer/adult social care worker will notify the designated social work lead/hospital team for each acute trust, who then must ensure the completion of the hospital assessment service on AIS and undertake a new contact to the appropriate community wellbeing team for D2A Adult Review, within/up to a **maximum** of 12 weeks review date and oversight of ongoing care and support needs. *(The review date can be a shorter date if the CSS AO feels the person does not need the package of care for an extended period of time and or the person has palliative care needs that need to be supported consistently as soon as possible by another provider).*

7.4 **Step 2 – If Change/modification required** - In the event it is assessed that any modification is required, either as an increase or decrease, the CSS assessment officer will initiate telephone contact, (whilst in the individuals home) requesting support/input from any of the appropriate Out of Hospital Hub virtual team, for an identified period of time (to be confirmed based on the individual's identified need/professionals judgement) which could consist of:

- Moving and handling support requirements – contact OT triage on tel: **07970 924202** (Disability Resource Team).
- Support with any shopping, social contact requirements – contact Care Co to contact the Community Hub for volunteer input.
- Re provision (increase or decrease) – CSS AO contact Brokerage -C&RT officer to initiate new CERT to Providers and thereafter follow usual process.

7.5 Following on from any identified potential modification, the CSS assessment officer will then scan and index the completed D2A Assessment (LTA form) by the end of the same working day. The CSS assessment officer or CSS TA will then notify the designated social work lead/hospital social work team to close the initial AIS Covid19 assessment. After which they will input a new contact to the relevant community wellbeing team in order to enable a review in approximately 3 months from the commencement of the revised care and support plan and or service.

7.6 At the point of the above review, point 7. 4 Step 2, whether confirmation of ongoing support, or any modification of ongoing care and support needs, the CSS assessment officer or ASC worker must then initiate a welfare rights referral/contact. This must be arranged, and where possible have commenced initial telephone checklists to gather financial information, within 3 - 7 days from hospital discharge.

7.7 **Pathway 2:** If a person is discharged straight to a D2A bed, an adult social care worker will use the Adults D2A care and support plan to determine whether it is appropriate to continue the initial trusted assessor D2A support identified, or whether any modifications of the package is required. E.g. occupational therapist input for moving and handling or aids/adaptations (if not identified earlier). If OT reablement input has not been identified at the earlier Pathways decision point, the adult social care worker, if thought appropriate, can contact the OT Triage contact number: **07970 924202** for further support.

7.8 The adult social worker will also have an initial overview discussion of capital limits for potential future social care charging with the person at this point, outlining that no charging will be applicable throughout the national emergency period but may occur after long term needs have been identified.

7.9 An initial contact should be made to the welfare rights team to initiate undertaking financial checklists. This must be arranged, and where possible, have commenced within 3 - 7 days from hospital discharge. Recording on AIS to show taken place.

7.10 **Pathway 3:** If a person is discharged straight to residential/nursing bed, an adult social care worker will use the Adults D2A care and support plan on AIS to determine whether it is appropriate to continue the initial trusted assessor D2A support provided, or whether any modifications of the package are required.

7.11 The adult social worker will have an initial overview discussion of capital limits for potential future charging with the person at this point, outlining that no charging will be applicable throughout the national emergency period but may occur after long term needs have been identified. Recording on AIS to show this has taken place.

Section 8 - Welfare Rights Contacts:

8.1 New Contacts as part of the D2A process:

8.2 Once a request for a financial assessment is received in the welfare rights office, an initial telephone contact will be made with the individual in order to arrange a planned telephone appointment with a welfare rights officer (WRO) at a convenient date/time. During this first contact staff will go through initial checklists with the individual.

8.3 Prior to the planned telephone appointment the welfare rights team will complete searches and all 'usual' pre visit checks.

8.4 When the WRO officer contacts the individual, the finance calculation form will be completed in the usual way, accept over the telephone, using the information the individual has at that time and will then be able to inform the individual of the likely future charge based on what has been discussed.

8.5 Individuals will be asked to email all proofs to the welfare rights team. (The individual could take a picture on their mobile and send them. If this cannot be completed the individual will need to post them).

8.6 The WRO will complete AIS case note and send out a letter to the individual/family (preferably by email) requesting the proofs required and confirmation of the provisional charge. Also included will be the consent sheet and direct debit form which will need to be returned to the council.

8.7 The WRO will enter a diary note in their calendar for 10 days, to chase the individual for the proofs, and if not received, allowing another 10 days, then repeat again. If still not received send a letter/email stating full cost.

8.8 Once proofs have been obtained or full cost letter sent, the welfare rights team will send though to assessments and payments to initiate charging once the emergency period is over.

Section 9 - Community Wellbeing Team (CWT) Review Process:

9.1 Reviews of initial care and support plans usually take place after a period of 6-8 weeks. However due to the anticipated demand as a result of the Covid19 pandemic in order to ensure capacity, and to prevent any bottlenecks due to any reduced staffing/resource capacity, this time frame has been adjusted to an anticipated target of a **maximum** of 12 weeks.

9.2 This is likely to be an initial telephone review, with the need for a face to face only in the event of a substantial change of need.

Section 10 - When a patient is transferred from an acute hospital bed to a Discharge to Assess (D2A) bed

10.1 In the event an individual is identified to be discharged into a D2A bed, e.g, social care step down (PSB, Active recovery etc) or health commissioned bed (see appendix 5) an allocated adult social care worker will be responsible for commencing the social care and support assessment/plan and arranging the next step in the care and support planning process. A person may be discharged into a D2A bed either because it has been deemed clinically appropriate (health to health transfer) or because the person is likely to require long term residential care or the care package to support them home is unavailable.

10.2 **Transport from Community Bed Settings:**

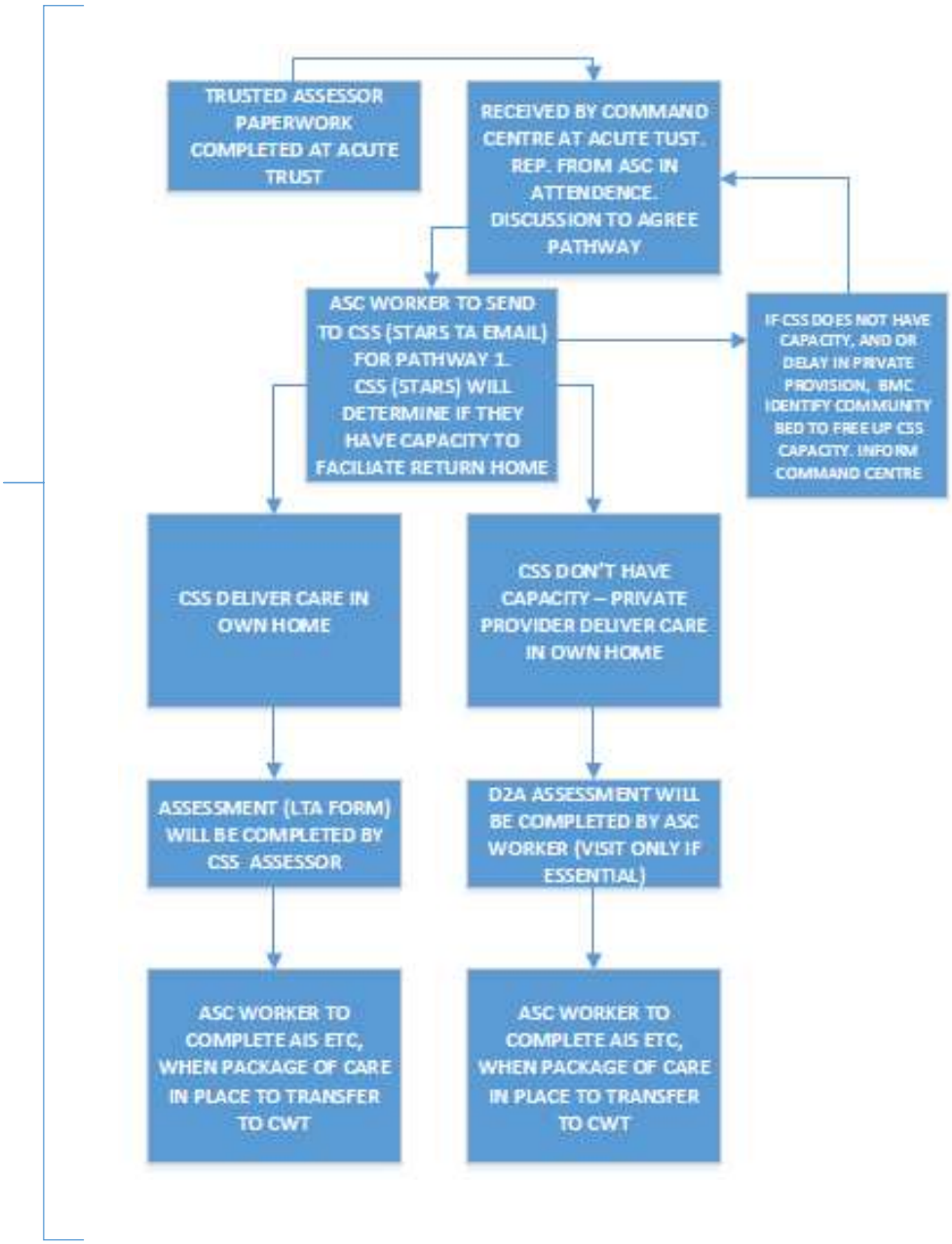
10.2 Any transport requirements necessary, as a result of initiating an additional step for the individual, from community bed settings to go Home, will follow usual processes:

- Family/Friends/Carers, in the first instance
- Taxi service, to be paid for by the individual
- Volunteer organisations e.g. British Red Cross, Age UK or any other alternatives if none of the above available
- Patient Transport Service and or NHS Volunteers (only in the event of identified clinical need/agreement from specific Acute Trust)

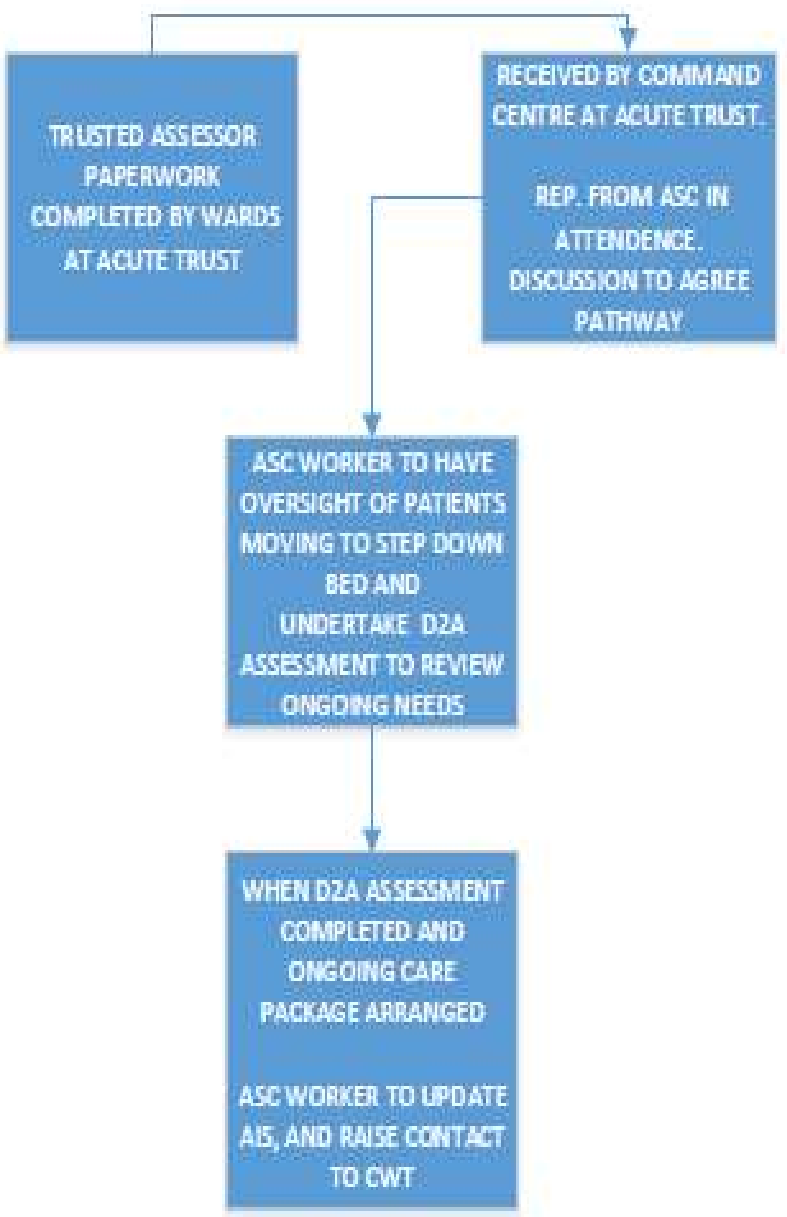
Appendix 1 Adult Social Care Worker Oversight – Easy Read Flowchart Pathway 1

Oversight from ASC worker for both CSS (STARS) and private provider pathway to ensure any issues are resolved e.g. switch to pathway 2.

Involvement from community hub required until transfer to CWT.



Appendix 2 Adult Social Care Worker Oversight – Easy Read Flowchart Pathway 2



BED ALLOCATION PROCESS:

INTERNAL TO ERYC:

PATHWAY 1 – IF CSS HAVE NO CAPACITY, OR PRIVIATE PROVIDER DELAY, INFORM BMC OF NEED FOR ASC COMMUNITY BED AND INFORM ASC HOSPITAL LEAD IF ONE AVAILABLE/BEIGN USED.

EXTERNAL PROCESS:

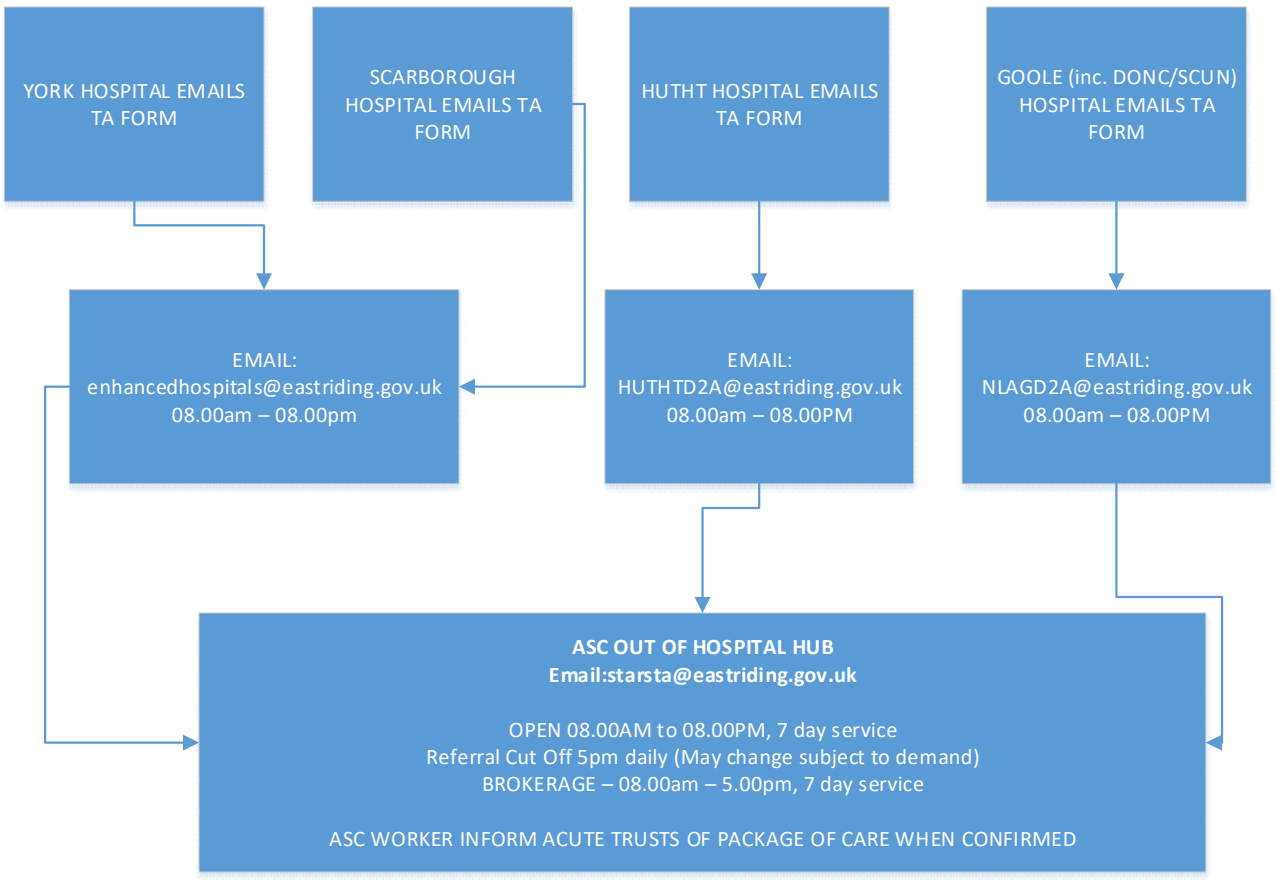
PATHWAY 1 – IF NO CSS CAPACITY/PRIVATE CARE DELAYED – IF NO ASC BED AVAILABLE INFORM ASC HOSPITAL LEAD TO CONTACT CHCP TO IDENTIFY THEIR CAPACITY

CSS TO SEND TRUSTED ASSESSOR FORM TO CHCP EMAIL/RING 01482 247111 TO IDENTIFY CHCP BED AVAILABILITY

PATHWAY 2 - ASC LEAD AT COMMAND HUB/DISCHARGE LIAISON TO ORGANISE ALL COMMUNITY BEDS

Appendix 3 – Contacts Details and Availability

NHS Acute Trust Command Centres	Contact number
York Teaching Hospital Trust	Discharge Liaison - 01904 725989
Scarborough General Hospital Trust	Discharge Liaison - 01723 342632
Hull University Teaching Hospitals (Hull Royal Infirmary/Castle Hill Hospital)	Discharge Liaison - 01482 623056
North Lincolnshire and Goole Hospitals	
Continuing Health Care – ERY CCG – D2A ERY Pathway 3 or 4 – For people who are particularly complex and or need clinical decision making -	01482 672006 or eryccg.continuingcare@nhs.net
Adult Social Care – hospital facing teams	**Contact number**
Enhanced Hospital Social Worker Goole – Nicole Fowler	01482 396861 (Monday - Friday 9am – 5pm) and OOH's (Monday – Friday 5pm – 8pm and weekends).
Enhanced Hospital Team Senior Social Worker – York, Scarborough and Bridlington Hospitals – Marianne Swaine	Work mobile: 07790542873* *NEW NUMBER
Hospital Senior Social Workers – Hull – Donna Hudson/Tina Cade/Charlotte Aziz	01482 623056



Appendix 4 - Trusted Assessor forms/guidance per Acute Trust (received)

Final TA Ax Form V2 HUTHT.docx

NEW DISCHAGE PATHWAYS v5.pdf

Trusted assessment form - Scarborough

Supported discharge pathway S

York FT Trusted Assessment Discharg

York supported discharge pathway2

**Awaiting Goole TA form/guidance

Doncaster TA.docx

Appendix 5 – Discharge to Assess Community Bed List

East Riding of Yorkshire Council capacity: accessed via HUTHT Discharge Liaison/ASC Lead worker:			
Level 2	3 beds	Woldhaven	Beverley
Level 2	2 beds	Rita Hunt Court	Beverley
Level 2	22 beds	East Riding Social Care Suite (Suite 20) Castle Road, Cottingham, HU16 5JQ Residential care beds Will accept double up care Don't need a move on plan or assessment at this time	Cottingham
Level 2	1 bed	Allendale	Hedon
Level 2	2 bed	Beverley Grange	Beverley
Level 2	1 bed	Brough Manor	Brough (GP cover has been confirmed from 27/04/20)
Level 2	3 beds	Glenfield	Driffield

City Health Care Partnership capacity: accessed via HUTHT Discharge Liaison/ASC Lead worker:			
Level 3 ICT	27	Rossmore 68 Sunny Bank, HU3 1LQ Residential care beds Will accept double up care Covered by CHCP Don't need a move on plan or assessment at this time	Hull
Level 3 Stroke beds	17	Rossmore	Hull
Level 3	10	Holy Name	Hull
Level 3	8	Victory Care	Hull
Level 3	4	Old Vicarage	Skidby
Level 3	5	Queens	Withernsea
Level 3	2	Brough Manor	Brough (Has GP cover)
Level 4	4	Highfield Wawne Road, HU7 4YG, Can accept nursing needs Hoist and 2 to transfer accepted Complex needs	Hull

Level 4	30	East Riding Community Hospital	Beverley
Level 4	12	Dove House Can accept nursing needs Hoist and 2 to transfer accepted Complex needs	Hull
Level 4	10	Holyname 240 Hall Road, HU6 8AT Level 4 beds, Can accept nursing needs Hoist and 2 to transfer accepted Complex needs	Hull
Additional:	2	Regency	Bridlington
	2	Mallard Rehab beds	Bridlington
	2	Mallard Pallative Care	Bridlington
	2	Allendale	Hedon
	24	Thornton Court - Great Thornton Street, Anlaby Road, HU3 2PH Single carer Non secure placement, can leave via doors in property	Hull
	8	Saltshouse 71 Saltshouse Road, HU8 9EH Residential care beds Will accept double up care Don't need a move on plan or assessment at this time	Hull
	6	Loran 106A Albert Avenue, HU3 6QE Residential care beds Will accept double up care Don't need a move on plan or assessment at this time	Hull

	8	Victory Care 101 Spring Bank, HU3 1BH Residential care beds Will accept double up care Covered by CHCP Don't need a move on plan or assessment at this time	Hull
	15 flats	Cherry Hinton Burnby Close, HU5 5RH Residential care beds Will accept double up care Don't need a move on plan or assessment at this time	Hull

Humber Foundation Trust capacity:			
Inpatient beds availability – ring 01947 899201 and ask to speak to one of the flow managers.	Dependent upon availability	Whitby & Malton Hospital	Malton
Contact via email: Janine.Tranmer@northyorks.gov.uk		St Celia's	Scarborough

Appendix 6 – D2A Assessment (LTA form) - Light Touch Assessment Form and Guidance

D2A - Light Touch Assessment Form - F

Light Touch Assessment Guidan

Appendix 7 – ERYC Finance Letter/Guidance


Financial Covid guidance FINAL 05 0


Financial Covid Letter FINAL 05 05 2(


Financial Covid signature sheet FIN/

Charging after hospital discharge:

Pathway 0

A simple discharge from hospital with no input from health or social care.

The charging policy does not apply.

Pathway 1

Support to recover at home; able to return home with support from health and or social care. The care and support received during the emergency period will be funded by the NHS. The local authority will be able to charge for any ongoing services after the emergency period has ended following a financial assessment.

Pathway 2

Rehabilitation in a bedded setting including a Discharge to Assess bed (D2A) because the patient cannot go straight home. The patient will flow to a D2A bed where the assessment will be undertaken. The care and support received during the emergency period will be funded by the NHS. The local authority will be able to charge for any ongoing services after the emergency period has ended following a financial assessment.

Pathway 3

There has been a life changing event and home is not an option at the point of discharge i.e. nursing care.

Where home is not appropriate due to a life changing event upon discharge from hospital the patient may need permanent residential or nursing care or a specialist placement. The care and support received during the emergency period will be funded by the NHS. The local authority will be able to charge for any ongoing services after the emergency period has ended following a financial assessment.

Conversations as part of the assessment should determine whether an individual will self-fund their care and if someone is above the capital limit case note records should ensure the position is clearly recorded for future reference.

GLOSSARY

ASC worker	Could be team manager/senior social work/social work or care co-ordinator in either hospital or community teams
BMC	Business Management and Commissioning (ERYC)
POC	Package of care (in the community)
CSS	Community Support Service (ERYC in-house home care)
CSS TA	Community Support Service technical assistant
CSS AO	Community Support Service assessment officer
C&RT	Contract and Review Team (ERYC)
CWT	Community Wellbeing Team (ERYC
D2A	Discharge to Assess Pathway
D2A Assessment	Discharge to Assess Assessment (AIS)
D2A Care and Support Plan	Discharge to Assess Care and Support Plan (Care and Support Plan on AIS)
D2A LTA Form	Discharge to Assess Light Touch Assessment Form (paper document)
Bedded setting	see Community Bed capacity lists for details